INVOLVING MEN IN REPRODUCTIVE HEALTH: A REVIEW OF USAID-FUNDED ACTIVITIES

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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ABBREVIATIONS

AED	Academy for Educational Development
AIDS	acquired immunodeficiency syndrome
AVSC	Association for Voluntary and Safe Contraception
CA	Cooperating Agency
CBD	community-based distribution
CDC	Centers for Disease Control and Prevention
CEDPA	Centre for Development and Population Activities
CYP	couple-years of protection
DHS	Demographic and Health Surveys
FHI	Family Health International
FP	family planning
FPA	family planning association
FPAK	Family Planning Association of Kenya
FPLM	Family Planning Logistics Management
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IEC	information, education, and communication
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IRD	Institute for Resource Development (Macro Systems, Inc.)
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU	Johns Hopkins University
JSI	John Snow, Inc.
KAP	knowledge, attitudes, and practice
MAQ	maximizing access and quality of care
MCH	maternal and child health
OR	operations research
PCS	Population Communication Services (project, JHU)
PHN	Center for Population, Health and Nutrition (USAID)
PIP	Population Information Program (JHU)
POPTECH	Population Technical Assistance Project
RH	reproductive health
SARA	Support for Analysis and Research in Africa
SDP	service delivery point
SEATS	Family Planning Services Expansion and Technical Support
STD	sexually transmitted disease
TA	technical assistance
TBA	traditional birth attendant
USAID	United States Agency for International Development
VSC	voluntary surgical contraception

EXECUTIVE SUMMARY

In order to determine the extent and nature of male involvement in USAID-funded reproductive health programs, the Population Technical Assistance Project (POPTECH) supported a team to conduct a survey and in-depth interviews with staff of USAID and USAID-funded Cooperating Agencies (CAs). Respondents included 22 USAID staff and staff of 22 CAs working on a total of 27 reproductive health projects. In this study, male involvement refers to any activity that seeks to expand the provision of reproductive health services and information to include men of all ages, either individually or as part of a sexually active couple.

Nearly all Cooperating Agencies surveyed are giving substantial attention to men and are developing effective reproductive health outreach and services for them. Roughly one-fourth of the clients served by CA programs are male. CAs estimate that they spend an average of 12 percent of their USAID project funds on male involvement activities.

The most common male involvement activities that CAs support are working with local male leaders to support FP/MCH activities and training providers to serve couples. In addition, several CAs are supporting advocacy, operations and social science research, STD/HIV/AIDS education and services, and community-based distribution (CBD). CAs are also working on condom promotion and vasectomy services.

CAs are doing more male involvement work than most population specialists assume. They do not always label their work as "male involvement." The amount of attention given to male involvement appears to have increased since the early 1990s. Due to funding limitations, however, most CAs do not plan to increase their male involvement programs in the next two years.

The vast majority of population and health professionals surveyed recognize the importance of male involvement. Most survey respondents agreed that men are adequately covered by STD/AIDS prevention projects. The main shortcoming is in family planning service delivery, which has focused primarily on women.

According to the CAs, the women-centered focus of family planning programs and the lack of funding for male involvement activities are the most important constraints to increasing male involvement activities. CAs also expressed a need for more training of service providers, operations research, information, education, and communication (IEC) materials, and NGO inputs. CAs are not so much waiting for a mandate from USAID, as they are hampered by the lack of clear encouragement and funding to implement large-scale male involvement interventions.

Both USAID and CA respondents indicated that the most important actions that USAID

can take to encourage male involvement are to disseminate lessons learned in male involvement; conduct operations research to test models for including men in service delivery; promote vasectomy and condom use; provide information on country-level strategies; and strengthen HIV/AIDS integration. CA respondents expressed a need for concrete facts, tested models, and funds to implement culturally appropriate, effective male involvement programs. Both USAID and CA respondents preferred integrating male involvement initiatives into existing projects when appropriate, rather than establishing a separate, new project devoted to male involvement.

LIST OF RECOMMENDATIONS

1. USAID should be more proactive in mobilizing other donors and national governments to support male involvement initiatives.

2. USAID should institutionalize male involvement within the Center for Population, Health and Nutrition (PHN) by appointing a male involvement coordinator and forming a Task Force on Male Involvement in Reproductive Health.

3. USAID needs to develop an internal consensus on the priority of male involvement relative to other programmatic objectives, articulate its views clearly to CAs, and ensure that CA contracts reflect these views.

4. USAID should identify and publicize cost-effective approaches to male involvement. Specific actions include: (1) identifying a USAID staff member to collect the best publications and track new publications on male involvement and ensure that they are distributed to CAs and USAID Missions; (2) requesting JHU/Population Information Program (PIP) to prepare an issue of *Population Reports* on male involvement; and (3) encouraging CAs to document their program experiences in male involvement, especially regarding financial sustainability.

5. USAID should ensure that condoms are universally available in all recipient countries.

6. USAID should request the appropriate CAs to develop indicators to measure the outputs and impact of male involvement programs. USAID should also develop performance indicators that reflect male involvement to measure progress in achieving the Center for Population, Health and Nutrition's (PHN's) strategic objective on family planning.

7. USAID should encourage CAs to conduct more research on men and male involvement programs and to collect more information on male clients.

8. USAID should give higher priority to providing appropriate information and services to young men.

9. USAID should request the Cooperating Agency responsible for the logistics management (currently, John Snow, Inc. [JSI]) to add a category for male involvement to the Population Projects Database form in order to track male involvement activities. Also, a common set of definitions of male involvement

activities should be developed to improve data consistency and accuracy.

10. USAID should disseminate guidelines for assessing access and quality of care related to reproductive health services for men.

11. USAID should ensure that women in development programs include a component reflecting the roles and responsibilities of men.

1. INTRODUCTION

1.1 Purpose of the Population Technical Assistance Project (POPTECH) Study

The United States Agency for International Development's (USAID's) Center for Population, Health and Nutrition (PHN) requested the Population Technical Assistance Project (POPTECH) of BHM International to support a study of male involvement in USAID-funded reproductive health programs (see Appendix A, Scope of Work). Specifically, POPTECH was asked to provide USAID with:

1. Information concerning the extent and nature of male involvement in USAID-funded health (limited to HIV/AIDS) and population programs; and

2. Recommendations for increasing male involvement in reproductive health programs, recognizing budget constraints.

1.2 Background

The United States is the world's largest donor to international reproductive health services and has gained an international reputation for testing and promulgating innovative interventions in family planning, AIDS prevention, safe motherhood, child health and other sectors. Of bilateral donors, USAID has the largest staff of population and reproductive health professionals.

The Cooperating Agencies (CAs) funded by USAID to provide technical assistance and subproject oversight and management have been an important partner in USAID's population and reproductive health programs. Accordingly, the POPTECH team collected information on male involvement from both USAID PHN Center staff and from CAs implementing centrally funded projects in population and health. Staff in USAID (bureaus) Missions and regional offices overseas and CAs funded directly by USAID Missions were not contacted due to time and resource limitations. However, many respondents had served in overseas Missions. Also, CAs working in contraceptive and biomedical research as well as those funded by subcontracts were not included in the CA sample.

1.3 Definitions

In this study, male involvement refers to any activity that seeks to expand the provision

of reproductive health services and information to include males of all ages, either individually or as part of a sexually active couple. Examples of male involvement activities include: male use of family planning (i.e., condoms, vasectomy, periodic abstinence, and withdrawal); men's support for female partners' choices and rights regarding reproduction and women's health; programs to increase couple communication; male responsibility within the family; men's use of health services for STDs / HIV / AIDS; and development of male contraceptive methods.

Reproductive health services refers to the provision of information and education, counseling, clinical service delivery, social marketing, school- or work-based programs, or any activity to promote reproductive and sexual health, including family planning; safe motherhood; breastfeeding; postabortion and postpartum care; the prevention, diagnosis, and treatment of STDs; and the prevention of HIV / AIDS.

Thus, this study covered all aspects of male involvement in reproductive health services, as listed above. Limited information was collected on activities related to the roles of men in child survival, prevention of domestic violence, and harmful cultural practices.

1.4 Research Methodology

The study was done in three stages:

1. The consultants used a questionnaire sent via e-mail and personal interviews to survey PHN Center staff to ascertain their perceptions of the importance of male involvement and the constraints to increasing or improving male involvement interventions (see Appendix B, "PHN Questionnaire on Male Involvement").

2. The consultants used a questionnaire (see Appendix C, Survey of Male Involvement Activities among CAs) to survey USAID Cooperating Agencies working in family planning and HIV / AIDS. They also interviewed senior staff of 16 CAs. Most of these staff were from the CAs' headquarters but a few were from field offices.

3. The consultants prepared a report summarizing their findings and recommendations.

The PHN and CA questionnaires were reviewed by two CAs and approved by USAID staff. The PHN questionnaire was pretested with several PHN staff before it was finalized. The CA questionnaire was pretested with four CAs and revised, based on their comments.

PHN respondents were self-selected from a sampling frame identified by USAID staff. The selective nature of the sample does not allow the survey findings to be generalized to USAID staff as a whole. A reminder e-mail was sent to potential respondents who did not meet the first deadline. Some of the CAs surveyed stated that they did not work in reproductive health and therefore did not complete the questionnaire. The researchers made many follow-up telephone calls to ensure a larger sample. Eventually, the majority of the CAs working in reproductive health completed the questionnaire or agreed to an interview.

Despite extensive review of the two questionnaires, PHN and CA respondents had difficulty answering some of the questions because they combined complex concepts and could be interpreted in different ways. Respondents also expressed concern that the results were likely to be biased because PHN and CA staff favorable to male involvement would be more likely to respond than those who were hostile or indifferent (see Appendix D, "Lessons Learned from this Survey," for more details).

1.5 Policy Statements Regarding Male Involvement

Recent international conferences have reflected a strong global consensus that male involvement is an integral part of reproductive health programs. The Programme of Action, approved by 180 nations at the 1994 U.N. International Conference on Population and Development (ICPD), contains an entire section on "Male Responsibilities and Participation." Among the recommended actions are:

> Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes.[1]

Condoms were the only contraceptive method specifically mentioned in the ICPD Programme of Action because of their importance in preventing STD infection as well as pregnancy. The prominence given to condoms underscores the importance of male involvement.

The 1995 International Women's Conference recognized that improving women's health

[1] United Nations. International Conference on Population and Development Programme of Action. Cairo and New York: United Nations, 1994.

and rights depends partly on changing men's perceptions of their roles and responsibilities. The Plan of Action[2] stresses the importance of men to women-centered reproductive health programs:

> Shared responsibility between men and women in matters related to reproductive and sexual behavior is essential to improving women's health.

To prevent unwanted pregnancies and STDs, including AIDS, the Plan of Action recommends increasing reproductive health counseling and services for men, especially condom promotion.

[2] United Nations. Fourth World Conference on Women: World Plan of Action. Beijing and New York, United Nations, 1995.

2. INSIDE USAID: POLICIES AND STAFF VIEWS

2.1 USAID Policies Regarding Male Involvement

USAID policy statements during the 1970s and 1980s said little about men as clients of family planning, reproductive health or maternal and child health services. It was generally assumed that women were the primary clients for these services. Also, USAID policies sought to be gender-free and hence used gender-neutral terms such as "clients," "couples," or "individuals."

In recent years, PHN has given more attention to gender-related barriers affecting reproductive health, especially those limiting access to high-quality services, and has begun to refer to both women and men as clients. The PHN strategic objectives adopted in 1995 specify men as clients for the first time. The first of the PHN's four strategic objectives is "Increased use by women and men of voluntary practices that contribute to reduced fertility."[3] The PHN's strategic plan notes:

> . . . Strategic Objective #1 explicitly refers to both women and men because the voluntary practices that relate to fertility reduction differ for women and men. Male responsibility in sexual and reproductive behavior is critical. Increased use by men of available methods and support by men for women's use of contraception, breastfeeding, and decisions concerning sexual activity, marriage, and childbearing are also essential.[4]

The PHN's strategic plan identifies male involvement as an area requiring additional effort. The plan mentions the large number of young men entering their reproductive years and states:

> In addition, programs must involve men more fully in family planning. More communication and shared decision making on family size and family planning matters between partners need to be encouraged, and male responsibility for sexual health, fertility, and child-rearing should be fostered.[5]

The PHN policy documents do not indicate the relative importance of the various

[3] U.S. Agency for International Development (USAID). Strategic Plan: Center for Population, Health and Nutrition. Washington, D.C.: USAID, December 1995, p. 1.

[4] USAID. Strategic Plan: Center for Population, Health and Nutrition, p. 16.

[5] USAID. Strategic Plan: Center for Population, Health and Nutrition, p. 17.

program initiatives, including male involvement. Judging from the performance indicators selected to measure progress toward achieving the strategic objectives, however, male involvement appears to have low priority in the family planning sector. Although Strategic Objective #1 mentions men, the performance indicators all pertain to women—contraceptive prevalence among women, breastfeeding, women's age at first birth and women's age at first intercourse. Male contraceptive use could be inferred from women's reports of use of male methods, but there is no separate measure of male behaviors. Similarly, four of the six performance indicators measuring quality of services are based on women's knowledge and fertility preferences.

On the other hand, the performance indicators for Strategic Objective #4 "*Increased use of proven interventions to reduce HIV/STD transmission*" specifically address male behaviors and access to condoms. These indicators rely heavily on Demographic and Health Surveys (DHS) of males while the family planning indicators are based only on Demographic and Health Surveys (DHS) of females.

In summary, male involvement is mentioned within the PHN strategic objectives, but it is not deemed important enough to measure as a sign of progress in family planning. Only in the HIV/STD sector is male involvement integrated into program strategies and performance indicators.

2.2 Views of PHN Staff Regarding Male Involvement

Of the 60 PHN staff who received the survey, 22 responded. The fact that the questionnaire was distributed in late July with a two-week deadline may have contributed to the 37 percent response rate. Some PHN staff may have been out of the office or preoccupied with other work. In addition, respondents may be a self-selected group, since the cover letter stated "If you are interested in this issue, we encourage you to participate." (See Appendix B for the cover letter and PHN Questionnaire on Male Involvement.)

Nevertheless, most of the respondents work in reproductive health and are in a position to influence male involvement activities. Nearly all of the respondents who identified themselves work in the Office of Field and Program Support and the Office of Population. Two divisions of the Office of Health and Nutrition—AIDS and Nutrition and Maternal Health—were also represented.

2.2.1 General Views on Male Involvement

Ninety percent of PHN respondents agreed that the USAID Global Bureau should place greater emphasis on activities and projects promoting male involvement. One

respondent commented:

> "I hope we can take up this issue in earnest. It's long overdue. At the core of this issue's volatility is the matter of defining who family planning is for and who should 'call the shots.' In our effort to be more attuned and responsive to women we have underappreciated the dualism of gender relations: those for whom fertility and conception is a possible consequence."

Another recognized the changing climate for male involvement activities:

> "I have been happily surprised by the recent flurry of activities."

Generally, respondents agreed male involvement should be integrated into "all appropriate PHN projects" but one suggested that male involvement be integrated "selectively—where it makes sense." Other respondents cautioned that men's programs should be expanded "only if using proven methods, or research to define effective methods" and "if nothing else must be sacrificed." This latter remark highlights the major challenge for USAID: at a time when the demand for family planning and other reproductive health services is highest, USAID funds for this sector have been cut sharply.

Some PHN staff stated that men are adequately covered by STD/AIDS prevention projects. The main shortcoming is in family planning service delivery, which has focused primarily on females. In biomedical research, respondents thought that the relative priority given to male contraceptive methods was appropriate. One respondent noted that maternity care programs do address male audiences in community outreach.

2.2.2 Constraints to Male Involvement

In order to learn more about possible influences on CAs' work, PHN staff were asked to rate the various factors that could serve to constrain male involvement in reproductive health. The most important constraints identified by PHN and CA respondents were at the policy level (see Table 1). PHN staff stated that *the lack of evaluation research and models* is the most important constraint while CAs believe that the *priority given to women's services* is the most serious constraint.

Notably, both PHN and CA respondents consider *reluctance among potential clients* and *administrative and logistical obstacles* to be minor constraints. This contrasts with traditional assumptions that men are not interested in family planning and reproductive health services and that services for males are more difficult to provide. Given USAID's accomplishments in policy dialogue and research, this finding gives

rise to optimism that male involvement activities can be influenced by USAID and CAs.

Table 1

Summary of Views Regarding Constraints to Male Involvement Programs in Reproductive Health

Constraint	Regarding its Relative Importance	
	PHN Staff	**CAs**
Lack of evaluation research and models	High	Medium
Perceptions of service providers and policy-makers	High	Medium
Community-level cultural constraints	Medium	Medium
Priority given to women's services	Medium	High
Reluctance among potential clients	Low	Low
Administrative and logistical obstacles	Low	Low

Note: This table presents the authors' subjective judgments, based on grouping the respondents' answers to similar questions. See table 2 for further detail.

The PHN respondents' ranking of constraints to male involvement in reproductive health is discussed below.

Lack of models. PHN staff identified the *lack of models on how to involve men* as the most important constraint to male involvement (see table 2). Several respondents said that program design is a major issue. One commented, "We need to demonstrate how to do it and what has been shown to work."

Lack of research. Consistent with this concern, the second most important constraint identified by PHN respondents is the *lack of research measuring results, impacts and benefits of male involvement*. Few respondents are comfortable with the state-of-the-art knowledge about male involvement. "We need examples of what works, where, under different conditions and cultures," stated one respondent. There is widespread feeling that unless there are more lessons learned and ideas disseminated service providers will not know how to design new locally appropriate initiatives to involve men, particularly without incurring new costs and requiring additional resources.

Local service providers. The constraint ranked third by PHN respondents is *perceptions and/or attitudes of local service providers.* PHN staff believe that negative attitudes of service providers lead to inadequate efforts to provide services to men. These attitudes appear to be changing, however, as one respondent wrote "many community-based

distribution (CBD) agents are beginning to realize it is absolutely essential to involve men."

Cultural factors. Many respondents identified *community-level cultural constraints* as a major concern. "The most important level is the community level," said one respondent. "However," she added, "for widespread sustainability we need [to change] upper levels too." Another respondent pointed out that there is nothing unusual about the challenge of promoting male involvement at the community level: "In most every sector . . . we [try] to overcome constraints. Many are 'cultural.'"

Policy-makers and program managers. The *reluctance of host-country policy-makers and of local program managers* to involve men are both seen to be moderate constraints which vary widely by country and by program: "In some countries this is a constraint; policy reform is needed. In other countries it is not a constraint." The most frequent comment by PHN respondents was: "Varies region by region, country by country [or by the] situation in each community."

Integrating male services. An equally important constraint is *difficulty integrating men into existing programs emphasizing women*. (CAs ranked this as the most important constraint.) PHN staff acknowledged that men are not welcome and not comfortable in many family planning programs. "Some clinics are simply set up for women and they do not encourage men. There are privacy issues," a respondent commented. Nevertheless, most respondents believe that men could be integrated into existing programs if program managers made an effort to include them. The lack of male involvement programs remains a major weakness: "[Male reluctance] is only a constraint because men are not being approached systematically."

Moderate constraints. Constraints that were considered to be of moderate importance include:

- *Male reluctance or opposition*. Respondents noted that male reluctance pertains mainly to family planning and that most men do use STD services when they are needed. Comments on male attitudes include: "Strong sentiment that if women can do it, why should I bother?" and "[Some] men are too macho." Some respondents, however, pointed out that attitudes vary greatly among individual men and groups of men: "[Male reluctance is] definitely present but not universal."

- *Perceived low cost-effectiveness of men's programs/services.* Most respondents believe that more data are needed to determine the cost-effectiveness of services for men relative to those for women. Some respondents stated that the cost-effectiveness of male involvement may be difficult to determine because it requires measuring the indirect influences men have on their partners' use of contraception.

Research costs are also a factor: "Some [policy-makers] consider the cost of research and information, education, and communication (IEC) needed for male involvement in some countries to be prohibitive. . . That is a legitimate concern."

- *Higher priority given to women's reproductive health.* Respondents acknowledged that women are given priority in family planning services. "I think there is a definite bias [toward serving women]," responded a Population Office staff member. "Read the project papers of many service projects." Some respondents objected to the implication of this and other questions that male involvement is separate from women's health. They pointed out that programs can give priority to women and still involve men in order to support women's needs.

- *Opposition due to loss of control of reproductive health decisions or loss of funds for women's services.* Opposition from women's health advocates is not considered to be a major constraint. A female respondent noted: "[Some] opposition exists, but among a minority of women's health advocates."

- *USAID perceptions and attitudes.* Most PHN staff believe that attitudes of USAID staff are not a major constraint and that USAID could play more of a leadership role in promoting male involvement initiatives. Several respondents indicated that they were "not really sure of Missions' positions." One stated, "Often Mission personnel feel that to design and implement programs for males will be very labor intensive."

- *Reluctance among women.* Several PHN staff stressed the importance of confidentiality for women. A staff member responsible for a maternal care project warned:

> "This [male involvement] has the potential to swing the wrong way. In service delivery to pregnant and delivering women, we seek more female health workers due to the cultural desires of women—and often men themselves—especially in Muslim societies."

2.2.3 Priorities Regarding Possible USAID Actions

PHN respondents' ratings of possible USAID actions to address male involvement largely reflect their views on constraints. The two highest rated actions are to: *disseminate lessons learned in male involvement* and *conduct operations research to test models for including men in service delivery* (see table 3). A related action—*provide information on country-level strategies*—was rated fifth out of the 10 actions specified in the PHN questionnaire.

Other highly rated actions include *vasectomy* and *condom promotion* ranked third and fourth respectively. Possible actions receiving moderate support are: *strengthening integration of family planning and reproductive health*; *emphasizing the importance of male involvement to CAs*; *strengthening gender analysis in project design*; and *developing male involvement indicators.*

Table 2

Constraints to Male Involvement in Reproductive Health

Constraints	Rating by PHN Staff (n=22)	Rating by CAs (n=27)
Lack of models of how to involve men	4.2	3.2
Lack of research measuring results, impact, benefits of male involvement	4.1	3.2
Perceptions and / or attitudes of local service providers	3.9	3.2
Community-level cultural constraints	3.7	3.3
Perceptions and / or attitudes of country-level program managers	3.6	3.1
Perceptions and / or attitudes of host-country policy-makers	3.6	3.3
Difficulty integrating men into existing programs emphasizing women	3.6	3.8
Reluctance among men	3.2	3.0
Opposition among men	3.0	2.6
Perceived low cost-effectiveness of men's programs / services relative to women's programs / services	3.0	2.8
Higher priority given to women's reproductive health	2.9	3.4
Perceived opposition among women's health advocates due to loss of control of reproductive health decisions	2.9	2.2
Perceptions and / or attitudes of USAID and USAID Missions about male involvement	2.9	2.2
Perceived opposition due to fear of loss of funds for women's reproductive health	2.7	2.2
Reluctance among women	2.7	2.6
Difficulty integrating men's reproductive health services into general medical services	2.4	3.0
Administrative obstacles	2.3	2.3
Logistical obstacles	2.1	2.1

Note: Ratings were based on a five-point scale: 1 = not a constraint; 2 = a minor constraint; 3 = a moderate constraint; 4 = a significant constraint; 5 = a major, important constraint.

Most respondents did not favor developing a new project on male involvement; rather they stressed the importance of integrating male involvement activities into existing projects, as appropriate. One respondent commented, "Ensure better integration—not necessarily new funding or new projects."

Some PHN staff are already encouraging CAs to undertake male involvement activities. One respondent noted: "I have specifically encouraged [my CAs] at . . . meetings and provided materials to country reps to stimulate projects."

Table 3

Ratings of Possible USAID Actions by PHN and CA Staff

Possible USAID Actions	Average Rating (scale)	
	PHN	**CAs**
Disseminate lessons learned in male involvement	4.5	4.2
Conduct operations research to test models for including men in service delivery	4.5	4.1
Improve and increase promotion of vasectomy	4.1	3.3
Improve and increase promotion of condoms	4.1	3.8
Support social science research in male involvement	NA	3.8
Provide information on country-level strategies to strengthen and expand male involvement activities	4.0	3.7
Strengthen HIV/AIDS integration/activities	NA	4.0
Strengthen FP/RH integration activities that include men	3.9	NA
Emphasize to CAs the relative importance of male involvement	3.7	3.3
Strengthen gender analysis in project design	3.5	3.3
Develop specific indicators for male involvement as part of overall CA project performance goals	3.4	3.3
Develop an RFA or RFP emphasizing involvement of men	1.7	NA

Note: Respondents were asked to rate each item on a five-point scale: 1 = not important; 2 = of minor importance; 3 = moderately important; 4 = quite important; 5 = of high priority importance.
NA = Not available

3. VIEWS OF COOPERATING AGENCIES

The Cooperating Agencies' questionnaire was sent to 42 organizations receiving PHN central funds as prime contractors or grantees (see Appendix C for the cover letter and questionnaire). CAs funded by USAID Missions were not included in the survey. Twelve of the 42 CAs stated that they did not work in reproductive health and did not fill out the questionnaire.

Of the 30 CAs working in reproductive health that received the questionnaire, 22 responded. Three CAs sent seven responses, each representing separate USAID-funded projects or regions funded under a larger project, resulting in a total of 27 questionnaires.

The POPTECH consultants also interviewed representatives of 16 CAs to obtain in-depth observations and gather additional information. These interviews added much insight and were very helpful in shaping this report.

3.1 Overall Attention to Males

Many CAs had difficulty determining the proportion of their funding and activities allocated to male involvement. Few CAs working in family planning collect data disaggregated by gender and the majority could only make general "guesstimates" of their level of effort spent on male involvement activities. In addition, many activities involving men are not specifically categorized as male involvement and therefore are tracked as part of other program categories. "Most of our activities," says a typical comment, "include a dimension of male involvement, but few are only male involvement projects." In other words, male involvement is a cross-cutting activity and, consequently, CAs are not well-equipped to generate detailed information on their various male involvement activities.

When asked to estimate the proportion of their budgets and activities spent on male involvement, CAs reported a higher level of activity than is reflected in their budget allocations. CAs reported that on average they spend about 12 percent of their USAID project funds on male involvement activities. More than half of the CAs said that they spend 10 percent or less of their project funds on male involvement; one-fourth spend between 11 and 20 percent; and a smaller proportion spend between 25 and 40 percent. In contrast, CAs report that 17 percent of their project activities fall into the area of male involvement. One explanation for this discrepancy is that training and community outreach cover many men, but CAs do not categorize these activities as male involvement when they estimate budget allocations.

Roughly three-fourths of the clients served by CA programs are female, while about

one-fourth are male. Two-thirds of the CAs (18 out of 27) consider adult men in couples to be one of their primary audiences. Roughly half of the CAs named male youth (aged 15-24) and adult men as primary audiences. Due to the lack of gender-disaggregated data, most CAs cannot readily determine how many males they are serving.

These findings demonstrate the need for clearer directives to CAs to collect data on male clients, male involvement activities, and related costs. A common set of definitions for male involvement activities would improve data consistency and accuracy.

3.2 Organizational Policies

Half of the CAs (14 out of 27) said they have statements of objectives or results packages that mention male involvement or male responsibility in family planning and health. Nearly 45 percent (12 out of 27) have objectives mentioning adolescent males. A slightly smaller proportion have objectives that refer to gender equity or other gender issues, couples, couple-friendly services, or men as partners. These objectives suggest some interest in male involvement and gender equity. However, CAs do not appear to refer to such documents in their everyday work. Very few CAs attached copies of their objectives statements or results packages as requested. Few CA staff could recall these statements with any precision or produce copies of them during interviews. Moreover, few CAs have either agency-wide or project-specific measurable objectives involving males or gender or are currently monitoring such results.

3.3 Expected Changes in Male Involvement Funding

Half of the CAs (12 out of 24) believe that their level of male involvement activities will remain about the same over the next two years. A third of them (8) say that such activities will increase slightly, one-sixth expect these activities will decrease slightly (2), and
one-sixth expect they will decrease significantly (2). Decreased activity will primarily result from either CA-wide or project-specific funding cuts that are planned or expected.

3.4 Views on Constraints to Male Involvement

CA respondents generally agreed with PHN staff on the major constraints to male involvement. CAs were most concerned about the practical problems of meeting women's needs while increasing men's access to services. The CA respondents ranked

the views of local decision-makers and providers at about the same level of importance as the PHN respondents. The CA respondents, however, appear to be less concerned than the PHN respondents about the lack of models and research on male involvement (see table 2).

Integrating male services. CA respondents rated *difficulty integrating men into existing programs emphasizing women* as the most serious constraint. "Maternal and child health (MCH) clinics are staffed and organized to serve women, not men," remarked one respondent. Another stated, "In our experience men are willing to participate, they just don't know how." CA respondents believe that the major reason men are excluded from existing programs is that programs simply have not made an effort, for various reasons, to target and serve men. One respondent wrote: "Most IEC, training, and evaluation for family planning is related to women. . . We believe that the issue is not opposition but our ignorance in properly addressing the issue to a male audience."

Some CA respondents believe that the perceived constraints to involving men in programs designed for women are exaggerated. They argue that some imagined constraints result more from inertia than from policies intended to protect women's privacy, lower costs, or simplify administration and logistics. Several programs that initially focused on women have increasingly involved male partners in order to increase initial acceptance or raise contraceptive prevalence rates.

Lower priority for males. A closely related factor—*higher priority given to women's reproductive health*—was rated as the number two constraint. CAs cited numerous examples of contractual requirements and performance indicators that reflect a strong emphasis on women's services. Two CAs pointed out that their contracts do not mention male involvement:

> "Our cooperative agreement says we should promote reproductive health, which suggests both partners. But men's role is not explicitly mentioned. Many of our objectives imply male involvement: 'improve interpersonal communication'; 'mobilize communities and community leaders'; 'improve the health of families'; and 'test innovative methods of providing reproductive health services.'"

> "Men's responsibilities are certainly a big part of our conceptual framework, but that part is not explicit in our cooperative agreement. USAID has not spelled out the roles of men in our scope of work, or how we are expected to involve men."

The use of couple-years of protection (CYP) as the major indicator of project outputs leads CAs to focus on female-oriented services. As one CA respondent said, "Donor agencies measure success only or mainly by CYPs. In effect this discourages family

planning services for males." CAs believe that their efforts to encourage condom use and promote vasectomy are not adequately reflected in CYP data. Other measures of male involvement such as increased spousal communication or men's support for their partners' use of contraception are not requested by donors and therefore not monitored. CAs said they have little incentive in USAID-funded projects to increase the involvement of men. A manager of clinic-based services noted, "Male involvement is a hidden factor in successful family planning programs requiring community mobilization, but is usually not documented."

CA respondents acknowledged that male involvement indicators are not easily defined or measured. For example, accompanying one's spouse to obtain family planning services could be either a sign of support or of control and domination. Furthermore, the link between some male behaviors and improved reproductive health is speculative; systematic research is needed.

CA respondents emphasized that it can take a long time to show results stemming from male involvement activities. Changing cultural norms and deeply entrenched attitudes requires gradual, persistent effort while donors generally look for concrete, measurable results within a few years.

Community values and decision-makers. Four factors related to local views—community-level cultural constraints and perceptions and/or attitudes of host-country policy-makers, local service providers and program managers—were ranked by CAs as moderate constraints. CA respondents characterized these gatekeepers as either convinced that men will reject male methods or inadequately motivated to push for male involvement initiatives. One CA respondent said that host country policy-makers have a "tremendous resistance" to involving men. Despite a general concern that men should share responsibility, policy-makers are generally convinced that "condoms and vasectomy just aren't accepted." Another respondent wrote, "managers themselves assume men will be resistant, but it is not always so." Another CA said, "In Africa, there is considerable awareness of the [male] issue [among program managers]. But this doesn't necessarily get translated into more than seminars on the subject."

Nonetheless many CAs have begun initiatives to raise awareness among local leaders and providers; like all constraints, community barriers can either be accepted or challenged by local CA staff. Describing community-level constraints in Ghana, one CA spoke of his agency's research to deal with negative attitudes about involving men, "The constraints are substantial, but so is willingness to work on the task. Some MCH providers raise issues about [male] partners, but they are a minority."

Lack of research. According to CA respondents, the *lack of research measuring results, impacts, and benefits of male involvement* is both a cause and an effect of having few programs focused on men. Because such research is limited and not widely

disseminated, program managers are unaware of program interventions that work and are reluctant to experiment. Similarly, because they do not generally collect and analyze data on their own male clients, program managers know little about male attitudes and practices.

One CA respondent said that as long as programs for men seem to be adequate, "the glass is half full" and the perceived need for research on men is less; but when the "glass is half empty—if programs for men are perceived to be less effective—then we believe more research is required." In other words, program managers who are not concerned that men are left out are unlikely to undertake research on males.

Examples of areas requiring more research include:

- Additional Demographic and Health Surveys of men or husbands, with large sample sizes, more questions, and behavioral indicators,
- A male involvement module added to DHS surveys of women to obtain more information on spousal communication and joint decision making,
- Operations research to determine cost-effective approaches to male involvement, strategies for integrating male services, and estimate average program costs,
- Operations research and evaluation studies to determine how program processes, including provider bias, client orientations, facility characteristics and gender of providers, affect male utilization of family planning/reproductive health services,
- More information on dual method use (i.e., a condom with a female method) and on the differences between men's condom use with their primary partners compared to their condom use with other partners,
- A better understanding among program planners of how men are involved in either enabling or deterring their partners' use of family planning and reproductive health services,
- More knowledge about the effect of male participation, support, and spousal communication on contraceptive use, fertility, reproductive health, violence against women, and harmful cultural practices, and
- Studies on communication between partners about reproductive health, fertility, contraception and sexuality.

Some CA respondents consider research on communication between partners to be the

highest priority.

Another CA respondent called for more studies of "community norms: old-fashioned, garden-variety community-level focus groups to design community-based approaches to involving men. This is just like any other community development effort that requires working with community groups to change traditional behaviors. It's not 'sexy' because it's not new." For example, she noted how little is known about vasectomy acceptance and to what extent it is a community-influenced or an individual choice.

Theoretical models of male behavior change are required, especially with regard to condom use. A respondent working in condom promotion said that there is little information on when, with whom, and why men use condoms; the differences between condom use within or outside of marriage; and the link between condom use and couple communication.

Lack of models. A related issue—*lack of models on how to involve men*—was rated by CAs as a moderate constraint. Although there are many examples of successful programs for men, many CA staff members are unaware of them and expressed interest in obtaining more information.

Integration into general medical care. *Difficulty integrating men's reproductive health services into general medical care* was considered to be a moderate constraint. CA respondents stressed the distinction between family planning and STD services. Integrating family planning into general health services is difficult because of the different nature of the services, but STD diagnosis and treatment are already very much integrated into medical services. Few CA respondents considered the barriers to adding family planning services to basic health care to be important. Most stated that integration mainly entails retraining some staff and reallocating some resources. One CA asserted that including clinics for men within general medical care might be popular with clients and would not be very costly.

Male opposition. CA respondents consider *reluctance or opposition among men* to be a minor constraint. While they recognize that some men are reluctant to seek family planning / reproductive health services, they consider program design to be a far more important constraint. This is in direct contradiction to the traditional assumption that the main reason for not serving men is "male opposition to family planning." Two CA respondents referred to this assumption as a self-fulfilling prophecy: service providers assume men are not interested and thus do not offer services and information that will attract them.

Minor constraints. Factors that CA respondents considered to be minor constraints are:

- *Perceived cost-effectiveness of men's programs/services.* One reason cited for CAs' disinterest in male clients is uncertainty about the costs of programs for men due to the lack of research on which approaches are most cost-effective. "We need to explore the relative cost effectiveness of [involving] men versus women for similar outcomes," writes one respondent. "We CAs are not paid to reach men," commented the director of one of the largest CAs.

- *Reluctance among women*. Most CA staff recognize that women-centered services help female clients feel comfortable, but they believe that female clients can and will adapt to the presence of male clients—as long as the women's privacy and confidentiality are respected.

- *Perceptions and/or attitudes of USAID*. CA respondents do not consider USAID to be either a positive or negative factor in male involvement. They are, however, concerned that the continued separation of family planning and STD programs will lead to a reduced emphasis on male involvement in family planning. Some respondents believe that USAID Missions are more supportive of male involvement than USAID/Washington. Sample comments are: "Local USAID staff of Missions usually know more about local needs than Washington." and "Field staff are mostly more responsible [about involving men] than people in Washington. They know you can't reach women without reaching men, and that programs driven by CYP goals do not focus enough on reproductive health."

- *Perceived opposition due to fear of loss of funds for women's reproductive health.* Despite USAID funding cuts for family planning programs, few CA respondents were concerned that male-focused programs would divert funds from women's programs. Most respondents said that male involvement funding could actually improve the effectiveness of programs for women because men receiving counseling would be less likely to object to (or withhold support for) family planning and STD prevention for themselves, their partners, or their peers.

- *Perceived opposition due to loss of control over reproductive health decisions.* Similarly, most CA respondents were not worried that men's programs might lead to women's loss of autonomy in reproductive health decision making. In general, CA respondents believe that men's programs will lead to positive male attitudes and behaviors that will increase men's responsiveness to their partners' needs and rights. One respondent from Africa commented: "We field people know more about this than you people here in Washington who ask this question. [We know] you cannot reach women very well if you don't reach their men too."

  Another respondent from Latin America noted: "[We] work in rural communities where male dominance is stronger and women are in most cases dependent, or follow males' . . . [directives] or rules. That is why involving men

in our programs is very important. Greater male involvement will have positive effects on women's physical and mental health. In our experience, empowering rural women without considering the male perspective *can* have in some cases a negative outcome for women."

- *Administrative and logistical obstacles.* Some CA respondents stated that condom shortages are major constraints in some projects. In general, CA respondents did not consider either administrative or logical obstacles to be serious constraints. One respondent said that condoms (unlike many female methods) tend to be more readily available during supply shortages because they can be obtained from nonclinical sources.

3.5 Agency-specific Constraints to Male Involvement

In addition to rating general constraints to male involvement, CAs also rated the primary constraints within their own Cooperating Agency to efforts to serve men in family planning/reproductive health programs. *Priority given to women's programs* and *the lack of funds* are the most important constraints they cited (see table 4).

Women's reproductive health given higher priority was rated as the most important constraint to the respondent's own agency. CAs acknowledged that family planning programs are women-centered and that it is difficult to shift from this focus. Finding ways to offer male-friendly services without altering the quality or volume of current service delivery is a major challenge.

Lack of funding specified to include male involvement activities was rated as the second most important constraint. CA respondents believe that new funding is needed to take on new activities and to cover costs related specifically to male-focused IEC, counseling, or service delivery. Further study of the cost of men's program (and CAs' attitudes toward costs) would be helpful to estimate funds requirements.

The third-rated constraint—*difficulty integrating males into existing programs*—is closely related to the top-rated one—*giving priority to women's services.* Many CAs are successfully adding male components to female-oriented services, but careful planning and monitoring are needed.

The *lack of models on how to involve men* was ranked fourth as a constraint by CAs. CAs have considerable experience in designing and implementing women-centered services but are uncertain how to reach males, particularly in nonclinical settings. As a CA program director commented: "Many service strategies focused on men to date have been very costly or have weak measures of process and desired outcome. We need more investment in the development of model services for men, both as individuals

and in couples."

Another serious constraint is the *lack of trained service providers.* CA staff are concerned that many service providers do not have adequate training to talk to men and couples about the sensitive issues of sexuality, fertility, and contraception. A large private voluntary organization observed that its greatest need in reaching men is both "better IEC and improved training curricula for our male [community-based] distributors."

Closely related to the lack of models are two other constraints: *the lack of research on potential impacts or results* and *lack of research on male involvement*. Some CA staff are concerned about the lack of knowledge of "what works," while others do not consider this to be an important constraint. The majority expressed uncertainty : are there too few male involvement activities, do they fail, are they not being evaluated adequately, or are the results not being disseminated?

CA respondents considered the *lack of IEC materials for and about men* to be a moderate constraint. Several CA respondents mentioned the lack of print and audiovisual materials on reproductive health for men. In order to facilitate male involvement within programs for African women, one CA respondent said that there is an urgent need for "more male-focused IEC materials on reproductive health, not more maternal child health materials and more IEC and counseling materials on STDs, links to HIV [and] high-risk behaviors."

Lack of in-country NGO involvement was rated as a moderate constraint. Some NGO partners appear to be less than fully committed to involving men, but respondents have not paid much attention to this issue.

CA respondents rated the following factors as minor constraints:

- *Not seen as part of our primary mandate or purpose.* Most CA staff consider male involvement to be consistent with their overall objectives; however, most CAs do not specifically mention it as a primary goal.

- *Perceived less cost-effective than women's programs.* Some CA respondents recognized that data on cost-effectiveness of male involvement programs are needed. However, one respondent remarked, "We don't have evidence that men's activities are cost-INEFFECTIVE either." No CAs collect data which can be used to compare the cost-effectiveness of programs for women with those for men. While cost concerns are an issue for some CAs, they are not of great importance to most.

- *Lack of direction from USAID/W on what to do.* Several CA respondents believe USAID should give more emphasis to male involvement as a priority, while

others are content with USAID's current policies and prefer to leave action to the CAs. Respondents also pointed out that USAID cannot encourage major initiatives at a time of severe budget cuts. One said that CAs need "clearer guidelines from USAID/W and Missions on male involvement activities they will support." Another commented, "Male involvement policy has meant holding a few seminars for USAID staff and some CAs, but little more." A large CA observed that it "rarely/never [receives] any direction from USAID/W."

- *Lack of information from USAID Missions.* CAs seem to be content with the guidance provided by USAID Missions.

- *Administrative constraints.* CAs are not hampered by administrative obstacles.

- *Logistical constraints.* CAs do not consider logistics to be a major constraint to male involvement except as they affect condom supplies.

- *Lack of internal CA strategies and goals.* Many CAs lack specific written goals and strategies to involve men. If project objectives related to men exist, they are not measurable. Most CAs lack indicators of male involvement and do not collect data disaggregated by gender that could be used in program monitoring and evaluation. As one respondent said, "We have no deliverables for men."

In sum, the most important constraints cited by CAs are the *women-centered focus of family planning programs* and *the lack of funding for male involvement activities.* CA respondents also expressed a need for more training of service providers, operations research, IEC materials, and NGO inputs. CAs are not so much waiting for a mandate from USAID, as they are hampered by the lack of clear encouragement and funding to implement large-scale male involvement interventions.

Table 4

CAs' Views on Constraints within Their Own Agency

Constraints within Own Agency	Rating (n=27)
Women's reproductive health given higher priority	3.4
Lack of funding specified to include male involvement activities	3.0
Difficulty integrating males into existing programs	2.9
Lack of models on how to involve men	2.9
Lack of trained service providers	2.8

Lack of research on potential impacts or results	2.7
Lack of research on male involvement	2.6
Lack of IEC materials for and about men	2.5
Lack of in-country NGO involvement	2.5
Not seen as part of our primary mandate or purpose	2.4
Perceived less cost-effective than women's programs	2.4
Lack of direction from USAID/W on what to do	2.3
Lack of information from USAID Missions	2.2
Administrative constraints	2.0
Logistical constraints	1.8
Lack of internal CA strategies and goals	1.7

Note: Ratings were based on a five-point scale: 1 = not a constraint; 2 = a minor constraint; 3 = a moderate constraint; 4= a significant constraint; 5 = a major, important constraint.

3.6 CA Views on Possible USAID Actions

CA respondents generally agreed with PHN staff on the appropriate actions by USAID (see Table 3). Both groups gave top priority to *dissemination of lessons learned in male involvement* and *operations research to test models for including men in service delivery*. CA staff also stressed the need to *strengthen HIV/AIDs integration/activities.*

Actions of moderate importance to CAs are *condom promotion*, *social science research*, and *information on country-level strategies.* Lower-rated actions are: *vasectomy promotion*, *emphasizing to CAs the importance of male involvement*, *strengthening gender analysis in project design*, and *developing male involvement indicators.*

CAs were not specifically asked whether they favor a new project to promote male involvement, but in interviews several CAs expressed their opposition to such an initiative. They believe that initiatives for men should be integrated throughout USAID-funded projects in reproductive health and that a special project on male involvement might lead some CAs to ignore this program element.

CA respondents agreed that reproductive health programs need to give special attention to male involvement, but they cautioned USAID to avoid making it the "flavor of the month." They pointed to USAID's tendency to focus on a topic for a short period and then shift its focus to some other concern. To meet USAID's interests, CAs may

cobble together reports of existing activities rather than undertake new approaches. As one respondent stated, CAs might "quickly dust off all their old male-focused activities, which they have been doing for 20 years, and tout them to their donors and competitors as something new and unique."

While CA staff agreed that USAID/Washington should be more vocal in encouraging male involvement programs, they would not welcome detailed directives or specific quotas. They prefer to design programs that are appropriate to the local setting and to have flexibility to decide how to include male involvement in their programs. The director of a large CA remarked, "Our agency would not want a directive about male involvement from USAID/Washington. That should come from both the Missions and the local NGOs we collaborate with in each area."

4. USAID-FUNDED ACTIVITIES INVOLVING MEN

4.1 Overview of USAID Activities Involving Men

CAs reported that they are supporting a wide range of male involvement activities. As shown in Table 5, CAs are active in every aspect of male involvement. Some CAs plan to undertake male involvement activities within the next two years. While other male involvement activities are possible, CAs currently have no concrete plans to undertake them.

The most striking finding from this compilation of activities is that the most common activity—done by 16 CA programs—"involving local male leaders . . . in support of FP / MCH / HIV activities." This high score suggests that CAs recognize the important role of community leaders as decision-makers, trend-setters and gatekeepers of information and services. CAs appear to be well aware of the need for community outreach to promote reproductive health.

The second-most common CA activities are "training providers to serve couples" and "adapting services to serve couples or be couple-friendly," done by 15 and 13 CA programs respectively. The high rank of these activities shows that many CAs are emphasizing couples as a unit, rather than targeting men separately. Still, the categories "adapting services to serve men or be male-friendly" and "training providers to serve men" did not fare badly, with 10 CAs supporting activities in each category. These findings suggest that CAs are ensuring that service providers have the necessary skills to counsel and serve both men and women, either together or separately.

In contrast, few CAs seem to be promoting male clinics. Three or fewer CAs currently support "offering male or couple clinic sessions, hours, sites" and "hiring male clinic workers to work with men." "Training traditional practitioners" is also supported by only three CAs, although seven CAs indicate that it is a possible future activity. Similarly, only five CAs currently support "organizing male networks," while seven CAs mention it as a possible future activity.

The level of CA support for advocacy, operations and social science research, STD / HIV / AIDS services and education, and community-based distribution indicates that CAs are actively working on male involvement in a variety of programmatic areas. CAs are also working on condom promotion and vasectomy services, although eight or fewer are involved in each type of activity.

It is likely that table 5 understates CAs' activities, since some CAs did not respond to the questionnaire or to POPTECH's requests for information on their activities. Also, it does not include activities of CAs working in contraceptive research, funded by USAID

Missions, and funded through subcontracts.

Table 5

Male Involvement Activities (in numbers) Reported by 27 CA Programs

Male Involvement Activity	Currently Supported	Planned within Two Years	Possible in Future
Adapting services to serve men or be male-friendly	10	3	1
Adapting services to serve couples or be couple-friendly	13	1	
Offering male or couple clinic sessions, hours, sites	3		5
Promoting vasectomy through IEC campaigns	5		4
Increasing access to vasectomy through training, expansion of service sites	7		2
Promoting condom use through IEC campaigns	8	2	3
Increasing condom sales	8	3	
Providing STD / HIV / AIDS services for men	8	3	1
Promoting STD / HIV / AIDS services through IEC	10	4	
Training providers to serve men	10	3	1
Training providers to serve couples	15	2	
Training traditional practitioners (healers, TBAs) to work with men	3	2	7
Hiring male community-based distributors	9	1	1
Hiring male clinic workers to work with men	2		2
Expanding workplace programs for men	7	4	2
Conducting research on male KAP in reproductive health	10	2	5
Conducting research on programs / services for men	12	2	5
Organizing programs for male adolescents	7	4	5
Organizing male networks (sports, entertainment, military, unions, etc.) to promote male involvement	5	2	7
Conducting research on male contraceptive methods	7		1
Conducting research on microbicides / spermicides to prevent HIV / AIDS	4		2
Involving local male leaders (e.g. Imams, chiefs) in support of FP / MCH / HIV activities	16		3
Conducting social science research on male involvement	10	2	5
Conducting evaluation of male involvement activities / projects	7	2	6
Working with policy-makers to promote male involvement	10	2	5
Supporting advocacy and other policy-related activities concerning male involvement	12	1	6

The researchers found no evidence that CAs exaggerated their male involvement activities in order to comply with the expectations implicit in the survey. Many CAs submitted detailed project reports, reflecting their genuine and long-standing interest in male involvement. CA representatives discussed programmatic issues related to male involvement knowledgeably and in depth.

4.2 Descriptions of USAID-funded Activities Involving Men

USAID-funded activities that involve males are briefly described below. These are illustrative descriptions rather than a comprehensive listing of CA activities with male components. Activities are organized by the type of intervention, and each entry provides the lead CA's name, the country, and the project title.

4.2.1 Involving Policy-makers and Local Male Leaders

Pathfinder International—Nigeria: PPFN Enhancement Project in North Nigeria. As part of its efforts to strengthen community linkages, the Planned Parenthood Federation of Nigeria (PPFN) is organizing sensitization seminars for influential community and religious leaders in four northern states.

Population Council—Bangladesh: Male Involvement in Family Planning. The National Institute of Population Research and Training held a workshop to develop a male involvement policy and strategy for the national program.

Johns Hopkins University (JHU)/Population Communication Services (PCS)—Egypt: The Minya Initiative. In a conservative, rural area of Egypt, the local health agency held workshops attended by more than 180 local religious leaders. These leaders addressed 18,300 men in public meetings and religious observances and distributed 9,000 copies of a booklet on family planning.

JHU/PCS—Oman: Al-Seeb Community Based Male Motivation Campaign. In 1995 the Oman Ministry of Health conducted a pilot campaign on the benefits of birth spacing for men with reproductive-age wives, as well as elders, community leaders, and policy-makers. Major activities included an inauguration ceremony attended by high-level government officials and community leaders and 18 community discussion groups.

4.2.2 Adapting Services to Serve Men and Couples

Management Sciences for Health—Madagascar: APPROPOP/PF Project. Since 1994 MSH has implemented a project to train employees of factories and banks to provide family planning counseling and non-medical contraceptives at the work site. In less than two years contraceptive prevalence rates at the various sites doubled and the incidence of
abortion-related illnesses and STDs declined markedly.

Population Council Operations Research (OR)/Technical Assistance (TA) Project—Egypt: Counseling Husbands of Postabortion Patients. The Egyptian Fertility Care Society is conducting a program in hospitals to involve the husbands of postabortion patients in counseling in order to improve recovery and promote contraceptive use.

John Snow, Inc. (JSI)/MotherCare—Bangladesh: Community Development Program. The Save the Children Bangladesh Office introduced a maternal health project in 16 remote rural villages. Although pregnant women were the primary target audience, their partners were also included because of their influence over decision making and use of health services. Counseling materials recognize the husband's role in obtaining appropriate maternity care and in notifying the local midwife of any danger signs and complications.

Population Council/INOPAL—Peru: VECINOS PERU. In Peru, the Ministry of Health found that dedicating afternoon clinic hours exclusively to family planning attracted more male clients.

4.2.3 Hiring Male Community-based Distributors/Educators

Population Council: Kenya. Increasing Male Involvement in FPAK's Program. In 1994-1995 the Family Planning Association of Kenya (FPAK) conducted a study comparing the use of male, female and mixed-team CBD workers in a province with low contraceptive prevalence. The study found that involving men as CBD workers and as targets for services did increase male contraceptive use and interspousal communication. The study also found that male CBD agents distributed more condoms and more female methods than female agents. This was attributed to the fact that female agents have more household responsibilities and consequently less time to spend on CBD work.

Centre for Development and Population Activities (CEDPA)—Mali: The Katibougou Family Health Project. This community-based family planning program in a rural district of Mali, begun in 1986, raised contraceptive prevalence by including male

fieldworkers in community health teams. After six years, contraceptive prevalence in the area had risen dramatically compared with the national rate. Although condom use was low (4% prevalence), many women stated that the male fieldworkers had changed their husbands' attitudes toward family planning and had stimulated more open communication between spouses about family planning.

CARE—Honduras: Community Agroforestry Project. As part of its agroforestry project, PACO, CARE is testing cost-effective and sustainable strategies to increase male participation in reproductive health. It is training male extension workers and developing educational materials for men.

4.2.4 Promoting Condom Use through IEC Campaigns

Futures Group/SOMARC, Family Health International/AIDSCAP and Population Services International: Subsidized Condom Sales. Condom sales are a major component of all social marketing projects and can be found in many developing countries. Some condom marketing projects are completely self-supporting. Condom promotional activities have used diverse channels, including mass media advertising, entertainment, point-of-purchase displays, public events, and film vans.

CEDPA—Nepal: Condom Day. In 1995 the Nepal Red Cross organized a one-day fair in 30 districts of Nepal. Communities held rallies and used a variety of activities and media channels to promote condom use and responsible fatherhood. Community health workers reported that this publicity has helped clients to negotiate condom use with their partners.

4.2.5 Increasing Access to Vasectomy

Association for Voluntary and Safe Contraception (AVSC)—Kenya. Several AVSC-funded projects in Kenya have made vasectomy more widely available and better known. Major activities include: conducting a "mystery client" study to determine how potential vasectomy clients are treated, establishing a male clinic in Nairobi, encouraging existing service delivery sites to offer services for men, promoting vasectomy through a mass media campaign and print materials, training community-based distributors in male motivation, and supporting community education by a group of satisfied vasectomy clients. The number of vasectomies increased sharply during the mass media campaign but decreased after it ended.

AVSC—India: Centers of Excellence Project. In order to expand vasectomy services, the Government of India has trained master trainers in no-scalpel vasectomy.

AVSC—Mexico. Public-sector vasectomy services have been greatly expanded following training of physicians in no-scalpel vasectomy. In the Social Security Institute and Ministry of Health clinics, the number of vasectomy clients has increased markedly in just a few years.

Population Council/INOPAL. Six operations research projects in Brazil, Colombia and Mexico tested various strategies for promoting vasectomy. Researchers concluded that the decision making process is heavily influenced by wives, other vasectomized men and health care workers and that mass media can be effective in publicizing service sites.

Futures Group/SOMARC—Jamaica: Marketing of No-Scalpel Vasectomy. The National Family Planning Board of Jamaica promoted no-scalpel vasectomy through print advertisements and direct mailings during 1995 and 1996. During the campaign, the number of vasectomies increased. The Board plans to launch a radio campaign for vasectomy in 1997.

4.2.6 Providing Comprehensive Reproductive Health Services to Men

Pathfinder International—Uganda. In several areas in Uganda, Pathfinder is working with religious and youth groups to develop community-based services and referral systems. These projects provide comprehensive reproductive health services, including vasectomy, condoms, STD treatment, and HIV/AIDS education and diagnosis. While women are the primary audience, men are also included.

4.2.7 Communicating with Men to Change Reproductive Health Behaviors

Family Health International (FHI)/AIDS Control and Prevention Project (FHI/AIDSCAP). In FY1995 the more than 400 projects supported under FHI/AIDSCAP educated more than 1 million males and trained more than 10,000 males. Roughly half of project activities reached male audiences.

JHU/PCS—Zimbabwe: Male Motivation and Method Expansion Project. The Zimbabwe National Family Planning Council has conducted two male motivation campaigns. The second campaign which focused on men aged 18-54 encouraged couples to discuss and practice family planning. In addition to a broad mass media campaign, community events, football matches, live dramas and musical shows were held. Exposure to the campaign was associated with increased contraceptive use.

JHU/PCS—Bolivia: Las Manitos National Reproductive Health Project. In 1994 the Secretary of Health conducted a national multimedia campaign to stimulate couples to

discuss reproductive health and visit clinics for information and services. The campaign reached 87 percent of reproductive-age adults; half of those exposed to the campaign said they intended to use family planning. During the campaign the number of new contraceptive users rose by 9 percent.

FHI/AIDSCAP—Zimbabwe: AIDS Education for Transport Workers. The Zimbabwe National Employment Council for Transport Operating Industries has provided AIDS education to more than 1.5 million transport drivers, commercial sex workers, hotel and service station personnel, customs and immigration officials, and other people who interact with drivers. The Council has sponsored educational sessions, drama performances, and distribution of print materials.

AVSC International—Turkey: Family Planning Education to Men. In Turkey's three largest cities, local service providers offer counseling and education on family planning to partners of women having abortions. Program staff report that the men have expressed interest in family planning and find the information useful.

JHU/PCS, AED/Support for Analysis and Research in Africa (SARA) project, and IPPF—Africa Region: Men's Participation in Reproductive Health Conference. Policy-makers and program managers from 14 African countries attended a conference on men's participation in reproductive health held in Zimbabwe in 1996. The conference covered policy/advocacy, IEC and IEC within service delivery. Participants prepared national action plans.

4.2.8 Outreach to Male Youth

IPPF/WHR—Caribbean Region: Under 20 Clubs. Family planning associations (FPA) in 12 Caribbean countries have organized clubs for youth in order to educate them about sexuality. The Under 20 Clubs train both male and female peer counselors to do individual counseling and make presentations to youth groups. Some clubs sponsor radio and television call-in shows and other outreach activities. The Belize FPA is working with out-of-school teenagers—training them in income-producing trades as well as providing sexuality education.

Pathfinder International and JHU/PCS—Uganda: HIV/AIDS Prevention Campaign. In 1995 the Ministry of Health conducted a mass media campaign directed to males between the ages 15-19 promoting safer sex in order to prevent HIV/AIDS. The campaign included songs, radio programs and spots, posters and newsletters, bicycle rallies, drama competitions, video shows, and soccer matches.

Family Planning Services Expansion and Technical Support (SEATS)—Eritrea: Community Mobilization. In 1996 the National Union of Eritrean Youth launched a

project to provide information on responsible sexuality, good parenting, and the benefits of later marriage to youth in the community and military service camp. The project also provides reproductive health services.

FHI/AIDSCAP—Ethiopia: Youth Anti-AIDS Project. The Save Youth Generation Anti-AIDS Association promotes AIDS education among out-of-school, unemployed youth through peer education, small group discussions, drama, print materials (a risk assessment card and calendar), and sports events. Nearly 30,000 people have been reached through football matches, street theater, puppet shows, skits, and contact with 240 peer educators. Male peer educators visit video parlors, bars and other places where young men gather.

Management Sciences for Health—Russia: Heart to Heart Project. The Centre for the Formation of Sexual Health in Yaroslavl is initiating the first peer counseling program in Russia. The Centre provides education and counseling to 12,500 young people annually.

JHU/PCS—Kazakstan: Reproductive Health Services Expansion Program. In 1995 the Human Reproductive Center of Almaty launched two multimedia campaigns to encourage young men and women to seek information about family planning. The campaigns used TV and radio spots, print materials and videotape presentations at health clinics and youth centers.

FHI/AIDSCAP—Haiti: Aba SIDA Project. Under the Aba SIDA project, local NGOs use a variety of approaches to reach young men. A social service agency targets low-income urban youth through a volunteer youth network and community-based organizations. Another agency uses peer educators to reach 10,000 youths. Both groups promote condom use and negotiation skills to ensure consistent condom use. Aba SIDA also sponsors a monthly radio call-in show on HIV/STD prevention and a weekly television soap opera about a young woman whose husband dies of AIDS.

4.2.9 Training Providers to Serve Men and Couples

Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) —Kenya: No-Scalpel Vasectomy Training Course. JHPIEGO developed a checklist for no-scalpel counseling and clinical skills and used it to conduct a pilot training course at the University of Nairobi in Kenya.

Population Council/Africa OR/TA Project II—Madagascar: Husband's Involvement in the Pre-Introduction Trial of NORPLANT®. The inclusion of husbands in NORPLANT® counseling and decision making was studied at two clinical sites. The study found that after one year, continuation rates were higher among women whose

husbands had participated in the counseling.

4.2.10 Conducting Research on Men's Programs/Services

Population Council/Africa OR/TA Project II—Ghana: Navrongo Community Health and Family Planning Project. Begun in 1994, this project seeks to develop new approaches to village-based health and family planning services. It is developing new modes of service delivery, community outreach and volunteerism. The first phase showed the importance of community liaison and outreach to men. In the second phase, the project will be expanded to a larger area and will involve male peer network leaders and soothsayers.

Deloitte Touche Tohmatsu/PROFIT: Review of Employer-based Projects. The PROFIT project's analysis of workplace family planning projects funded by USAID over the past decade provides an overview of lessons learned as well as recommendations for future directions.

4.2.11 Conducting Research on Male KAP in Reproductive Health

Macro/Institute for Resource Development (IRD). In 1996 Macro/IRD issued a report on men's fertility, contraceptive use, and reproductive preferences based on Demographic and Health Surveys of males in 15 countries, mostly in Africa. Male surveys in additional countries are planned.

U.S. Centers for Disease Control and Prevention (CDC). The CDC has provided technical support for Young Adult Reproductive Health Surveys of males and females between the ages 15-24 in Romania and eight countries in Latin America.

EWCPOP. The East-West Center Program on Population is supporting a survey of males and females aged 15-24 in the Philippines and a study of male-female discussions regarding family planning in India.

AED/SARA—Africa: Reproductive Health Research Network for Francophone Africa. In 1995 and 1996 the Reproductive Health Research Network for Francophone Africa discussed male involvement topics during its annual workshops. Topics have included social norms, the need for couple-oriented services and male infertility.

Other CAs have conducted studies of males as part of project planning and evaluation. These CAs include AVSC International, FHI, JHU/PCS, Program for Appropriate Technology in Health and Population Council.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Major Conclusions

Nearly all Cooperating Agencies are giving substantial attention to males and are developing effective outreach and services for males. CAs are doing more male involvement work than most population specialists assume. They do not always label their work as "male involvement." The amount of attention given to male involvement appears to have increased since the early 1990s. Due to funding limitations, however, most CAs do not plan to increase their male involvement programs in the next two years.

The vast majority of population and health professionals surveyed recognize the importance of male involvement. Most respondents agreed that men are adequately covered by STD / AIDS prevention projects. The main shortcoming is in family planning service delivery, which has focused primarily on females.

According to the USAID and CA respondents, the most important actions that USAID can take to encourage male involvement are: disseminate lessons learned in male involvement; conduct operations research to test models for including men in service delivery; promote vasectomy and condom use; provide information on country-level strategies; and strengthen HIV / AIDS integration. CA respondents expressed a need for concrete facts, tested models, and funding to implement culturally appropriate, effective male involvement programs. Both USAID and CA respondents favored integrating male involvement initiatives into existing projects, as appropriate, rather than establishing a separate, new project devoted to male involvement.

5.2 Recommendations

Mobilizing Donor Support

1. USAID should be more proactive in mobilizing other donors and national governments to support male involvement initiatives.

Although this report focuses on increasing male involvement in reproductive health programs "within budget realities," as directed by USAID in our Scope of Work, the authors wish to emphasize that funding is a major constraint to achieving this goal. It is true that there is considerable scope within existing budgets to strengthen male involvement policies and programs; we elaborate on these opportunities below. Nevertheless, USAID needs to recognize that making major progress in male involvement will require additional funds. Factors that lead us to this conclusion are:

- **Males as a distinct audience**. Additional research is needed to learn more about the knowledge, attitudes and practices of specific male audiences. Outreach strategies, messages, information channels, and services need to be tailored to specific male audiences. Programs that reach male-only groups are often highly effective in changing attitudes and creating a supportive climate for improved spousal communication and joint decision making on matters affecting reproductive health.

- **Providing services to males**. Males have special needs for reproductive health services which are usually not addressed in current programs. For example, infertility diagnosis and counseling for sexual dysfunction may need to be added. Service providers need special training to ensure that they have the skills to provide counseling and services to males and couples. Hiring male counselors and fieldworkers often makes a big difference.

- **Sheer numbers of men**. Just as the numbers of reproductive-age women are rising rapidly due to past population growth, so are the numbers of men and male adolescents.

- **Hard-to-reach groups**. Special interventions are needed to reach rural men, especially those in traditional cultures, and male adolescents.

- **Changing social norms**. In the long run, programs need to address the social norms underlying male/female relationships. Values such as male dominance, gender roles, sexual mores, marriage and family relations all have a profound effect on reproductive health.

A CA leader stated, "No matter how hard USAID might try to proselytize male involvement, no amount of deadpan persuasion will work. USAID must now provide strong leadership and funds, as well as provide the CAs with technical assistance, if they expect CAs to serve more men." A long-term, multifaceted effort is needed to extend reproductive health information and services to males of all ages.

Existing resources can be stretched to meet some of these needs. The sheer volume of male involvement activities currently underway attests to the resourcefulness and ingenuity of CAs in finding ways to support new activities. Most CAs are doing a good job of incorporating males into their current programs and making services more male- and couple-friendly. Also, some male involvement activities have become self-sustaining after the initial investment in start-up costs. For example, many condom marketing projects have become entirely self-supporting within a few years of their inception. Still, USAID needs to take a leadership role within the international development community to ensure that meaningful action is taken toward achieving

the ICPD goals regarding male involvement.

Institutionalizing Male Involvement within PHN

2. USAID should institutionalize male involvement within PHN by appointing a male involvement coordinator and forming a Task Force on Male Involvement in Reproductive Health.

PHN and CA staff would like USAID to make a sustained, long-term commitment to strengthening male involvement in reproductive health. This commitment will require a more systematic effort by PHN to encourage, monitor and evaluate male involvement activities. As a CA project director wrote, "Like most other USAID initiatives, if male involvement is to become a true priority in project implementation, then there will be a need to structure, organize, as well as monitor and evaluate the benefits of this prioritization."

The PHN needs to designate a staff member to serve as the coordinator of male involvement programs and provide ongoing backstopping. This coordinator could identify opportunities for policy and program inputs, share information, and maintain a dialogue with CAs. Given the present demands on staff time, the coordinator could work on male involvement part-time and could delegate specific actions to other PHN staff.

Many PHN staff members are interested in male involvement and work on various facets of male involvement. They could form the nucleus of a task force that would examine USAID initiatives in male involvement, recommend specific actions, and disseminate information to CAs and USAID Missions. Task Force members could conduct training sessions for PHN staff and organize briefings on exemplary male involvement projects and important research findings.

In the short-term, the male involvement coordinator and task force can help to clarify the priority of male involvement relative to other programmatic concerns. In the long-term, they will be tangible evidence of USAID's continuing commitment to male involvement.

Male Involvement as a Component of CA Projects

3. USAID needs to develop an internal consensus on the relative priority of male involvement versus its other programmatic objectives, articulate its views clearly to CAs, and ensure that CA contracts reflect these views.

Many CAs reported that they receive mixed messages from USAID regarding the level

of effort they should devote to male involvement. In speeches and documents, USAID officials include male involvement in long lists of programmatic concerns such as quality of care and gender equity, however, the priority of male involvement relative to these many concerns is unclear.

Nearly all CAs stated that their contract/cooperative agreement did not mention male involvement as a project goal or area of focus. The lengthy list of project outputs or deliverables specified in CA contracts contains few, if any, outputs related to men, except as acceptors of condoms and vasectomy. One CA manager remarked, "We have 134 indicators to track in our cooperative agreement. Not one deals explicitly with male involvement—or even gender issues."

Staff of the large CAs working in service delivery explained that the use of couple-years of protection (CYP) as a measure of outputs was a major factor in their focus on female-centered services. The large number of condoms needed to achieve one CYP (150) and the higher level of effort needed to increase use of vasectomy have discouraged program managers from investing in male involvement. Women-centered programs are a surer and generally less costly way to generate CYPs. A pragmatic project manager would almost certainly conclude that male involvement activities are an unnecessary diversion from achieving required project outputs.

USAID needs to give CAs clearer guidance regarding the relative priority to be given to male involvement. Most CAs must juggle a large number of "priorities" and shift resources to match USAID's changing country and program priorities. While many CA leaders welcome clearer guidelines on male involvement, they also want to retain some flexibility to respond to local conditions and opportunities. A directive to reach specific numerical targets would not be well received and could be treated as a perfunctory exercise rather than a mandate to push into uncharted areas. Nevertheless, some changes in contractual language, such as inclusion of male involvement in project objectives and outputs, could inspire CAs to embark on new male involvement initiatives. CAs would like encouragement from USAID to try innovative approaches and to take on challenges such as reaching rural males and adolescents. This encouragement needs to be reflected in project outputs or deliverables so that CAs can receive credit for taking on difficult tasks without being penalized for lower-than-expected CYPs.

Virtually all CA leaders are in favor of the idea of strengthening male involvement programs. Most PHN and CA respondents are strongly opposed to the creation of a new project devoted to male involvement. They believe that all CAs should be working on this cross-cutting issue and that there is no need for a new project to be created. Accordingly, we do *not* recommend the creation of a new project for male involvement.

Information Dissemination

4. USAID should identify and publicize cost-effective approaches to male involvement. Specific actions include: (1) identifying a USAID staff member to collect the best publications on male involvement and track new publications on male involvement and ensure that they are distributed to all CAs and USAID Missions; (2) requesting JHU/Population Information Program (PIP) to prepare an issue of *Population Reports* on male involvement; and (3) encouraging CAs to document their program experiences in male involvement, especially with regard to financial sustainability of such programs.

Many CAs expressed a strong desire to learn more about effective male involvement programs. To some extent, existing publications and research studies can meet this need. Most CA staff have not seen recent publications that reflect state-of-the-art thinking about male involvement, however, they are eager to obtain more information. Sending CAs a packet of the best publications would help to share information on the most effective approaches.

In addition, an up-to-date compilation of findings of recent DHS surveys, KAP studies, operations research, and project evaluations pertaining to male involvement is needed. Much of the program experience from STD / HIV / AIDS prevention and condom social marketing programs would be extremely valuable in planning and implementing male involvement programs. The most cost-effective way to provide this information to large numbers of decision-makers and program managers worldwide is through *Population Reports*. A decade has elapsed since the last issue of *Population Reports* on men; an update is long overdue.

A careful analysis of the factors contributing to financial and programmatic sustainability of male reproductive health programs is needed. In many countries retail sales of condoms have generated a profit. In addition, some medical services for men such as physical examinations required for employment and counseling regarding sexual problems have generated income. On the other hand, some male-oriented services have failed to generate adequate numbers of clients. CAs and their local counterparts have developed considerable program experience and their insights could be disseminated more widely.

Universal Availability of Condoms

5. USAID should ensure that condoms are universally available in all recipient countries.

Some CAs reported that they had observed problems with condom supplies in some

countries. Since condoms are a crucial element in reproductive health care and the only reversible male contraceptive method, program managers need to make a special effort to ensure that they are universally available and affordable. The ICPD Programme of Action recommends that: "Condoms and drugs for the prevention and treatment of sexually transmitted diseases should be made widely available and affordable."[6]

While USAID does not have to assume responsibility for supplying condoms, it should ensure that each country program makes condoms widely available through multiple public and private sources. USAID can facilitate contacts with other donors and provide technical assistance in logistics management and procurement procedures.

Development of Male Involvement Indicators

6. USAID should request the appropriate CAs to develop indicators that measure the outputs and impacts of male involvement programs. USAID should also develop performance indicators that reflect male involvement to measure progress in achieving PHN's objective on family planning.

Within the family planning field, surprisingly little work has been done to develop indicators of male involvement. The *Handbook of Indicators for Family Planning Program Evaluation*,[7] a comprehensive listing of 103 indicators covering all aspects of family planning programs, does not include any indicators specific to males. As previously discussed, none of the five performance indicators that measure progress towards achievement of PHN's objective in family planning refer to men or methods involving men; all are indicators of women's behaviors.

In contrast, the performance indicators for PHN's objective on prevention of HIV/STDs specify male behaviors and access to condoms. Based on national survey data, HIV/STD programs will assess condom use in (a) regular partnerships and (b) "casual" relationships. Most CAs working in family planning are unaware of this indicator and do not collect data that differentiates between regular and casual partners. Countries that do not have national surveys of males will have to identify other data sources.

CA staff believe that the development of indicators for male involvement activities is an essential prerequisite to a reassessment of program priorities. One CA respondent remarked, "Existing funds will allow for larger male involvement interventions only

[6] United Nations. International Conference on Population and Development Programme of Action. Cairo and New York: United Nations, 1994.

[7] Jane T. Bertrand, Robert J. Magnani, and James C. Knowles. Handbook of Indicators for Family Planning Program Evaluation. Chapel Hill, NC: Carolina Population Center, University of North Carolina, 1996.

when we change the rules for assessing success and impact."

The challenge in developing indicators for male involvement in reproductive health is to capture men's multiple roles as contraceptive users, sexual and marital partners, members of a decision-making unit, gatekeepers to information and services, opinion leaders and
policy-makers. Appendix E, "Male Influences on PHN Objectives," lists some of the issues to be considered in developing male involvement indicators. Caution is needed when devising and interpreting indicators reflecting male support. Behaviors that appear supportive such as accompanying one's partner or family member to the clinic or discussing contraceptive use could in reality be a form of domination or control in the context of the couple's relationship and culture.

Support for More Research on Males

7. USAID should encourage CAs to conduct more research on men and male involvement programs and to collect more information on male clients.

PHN and CA staff recognize the need for various types of research to support male involvement, including DHS and KAP surveys, in-depth studies, operations research, and program evaluation. The paucity of studies and documented program results to date have led to an over-reliance on a small number of program experiences. Relying on this limited knowledge base is likely to lead to faulty assumptions and inaccurate generalizations.

USAID can play a constructive role in identifying important research topics and encouraging CAs to undertake appropriate studies. It can also require CAs working in service delivery to collect more information about their male clients and to disaggregate service statistics by gender.

Greater Attention to Young Men

8. USAID should give higher priority to providing appropriate information and services to young men.

Recent USAID initiatives such as the FOCUS project have given more attention to young people, including males. Nevertheless, many family planning programs tend to focus on young women, since they are at risk of pregnancy and complications from childbirth or unsafe abortion. Young men, especially out-of-school youth, often do not have a reliable source of reproductive health information and regular health care. Investing more resources in raising young men's knowledge of reproductive health can save money in the long run by preventing unwanted pregnancy and STDs/HIV/AIDS. If young men adopt appropriate values and behaviors early in life, they are more likely

to carry them forward into adulthood.

Tracking Male Involvement Activities

9. USAID should request the Cooperating Agency responsible for the logistics management (currently JSI) to add a category on male involvement to the Population Projects Database form in order to track male involvement activities. Also, a common set of definitions of male involvement activities should be developed to improve data consistency and accuracy.

In order to obtain up-to-date information on USAID-funded male involvement projects, PHN should include male involvement as one of the program activities listed in the Population Projects Database form that CAs fill out for each subproject. The Database is maintained by the Family Planning Logistics Management (FPLM) project of John Snow Inc. (JSI), and there is room on the form to add a new category. Once this system is in place, JSI/FPLM could generate a list of male involvement subprojects and/or descriptions of subprojects of particular interest at the request of PHN, USAID Missions and CAs.

Assessing Access and Quality for Males

10. USAID should disseminate guidelines for assessing access and quality of care related to reproductive health services for men.

Consistent with USAID's concern for improving access and quality of care of services for females, PHN's six Maximizing Access and Quality of Care (MAQ) program objectives can be applied to the assessment of services provided to male clients at service delivery points (SDPs) in terms of male clients. Appendix F, "A Framework for Assessing Access and Quality of Care for Males," provides examples of questions that can be used to assess access and quality of care for men as well as women.

Strengthening Gender Analysis in Project Design

11. USAID should ensure that women in development programs include a component reflecting the roles and responsibilities of men.

USAID can ensure that the Gender Plan of Action is gender-balanced and that the roles and responsibilities of men are considered in efforts to improve women's lives. The senior policy advisor on women in development could be asked to ensure this balance and reinforce the integration of gender issues facing both genders into USAID policies across sectors, and particularly in the health and population sectors.

Re-engineering activities to incorporate gender issues can include consideration of both genders. Such re-engineering can apply to project design, the development of new indicators and training that encompasses all USAID functions, including monitoring and evaluation, staff orientation, and technical sectors.

APPENDICES

MALE INVOLVEMENT STUDY

Rationale The Plan of Action for the Cairo International Conference on Population and Development called upon donors and providers to increase the involvement of men in family planning and reproductive health programs, to emphasize men's shared responsibility, increase the support of men for women's use of contraception, and generate demand among men for existing male methods of contraception Planners and decision makers in international family planning and reproductive health programs are increasingly taking the male role into account in the design of programs and evidence is beginning to emerge that this can have a positive impact on both male and female reproductive health

Purpose: The purpose of this survey is to provide USAID with information concerning the extent and nature of male involvement in USAID-funded health (HIV/AIDS) and population programs and to provide USAID with recommendations (within budget realities) to increase male involvement in reproductive health programs

Scope of Work

The work will be done in four stages 1) The consultant(s) will contact selected PHN Center staff to ascertain perceptions of the importance of male involvement, constraints to increasing - or improving the nature of male involvement. 2) The contractor will survey USAID PHN cooperating agencies in family planning, HIV/AIDS, safe motherhood and breast feeding The survey will produce information on the nature and extent of male involvement in their policies and programs, information on the CAs perceptions as to the pros and cons of increasing male involvement in their programs specifically, and in reproductive health programs in general The survey will develop information on perceived constraints (financial, programmatic, cultural, etc) to increasing male involvement The contractor will also review written documents, policies, guidelines, IEC material submitted by the CAs and will interview selected representatives 3) A draft report will be submitted to USAID in writing and in a verbal presentation. 4) A final report will be submitted incorporating USAID's written comments and those received during the presentation of the draft Note activities including males are within the scope of the survey

Summary Schedule

(Dates represent approximate time periods and do not assume full-time (40 hr work week)

1 May 20-21 "Kick-off" - Cooperating Agency Meeting
Discuss survey and proposed questionnaire with selected CAs

2 May 22 - June 1 Preparation of brief note to PHN Center Officers to solicit their input

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3 June 1-15 Preparation of questionnaire for survey of CAs

4 June 15-30 Contacts with PHN Officers Distribution of questionnaire to CAs with deadline of July 31 for response

4 July/August - Telephone and in-person interviews with selected CAs

5. August - Complete interviews and analysis

6 September 1- October 15 - Report writing

7 October 15 - Submission of draft to USAID for comment and presentation of results is USAID requests

8 November 15 - USAID comments due

9 December 1 - Final Report

Report

The report should contain a description of what types of programs currently have some male involvement focus It should also provide brief examples of, where in the opinion of the consultants, the Office of Population could provide a better climate for promoting male involvement among the cooperating agencies, and where and how existing programs might benefit from greater emphasis on male involvement The report should clearly discuss the CAs concerns/issues with increasing the emphasis on male involvement For example, added cost, lack of good indicators, diversion of resources needed to provide services to women, lack of research, etc The report should also mention notable success stories The report should contain specific shorter term recommendations for improving male involvement, taking into account budget constraints and recommendations for the long-term If the report has potentially "sensitive" information in it then it may be divided into two parts, one for internal use by USAID and a second part that will receive wider, public distribution

Administration & Logistics

Office Space - POPTECH
Reproduction of Questionnaire and Reports - POPTECH
Communications - POPTECH
Travel (domestic only) - POPTECH
Mailing or emailing of questionnaire and receipt of responses
USAID, G/PHN/POP

Level of Effort 2 persons for approximately 30 days each

July 24, 1996

Dear PHN Colleague

As part of its study of policies and programs related to male involvement in reproductive health, the PHN Center has asked us to conduct an informal survey of USAID-funded Cooperating Agencies and PHN Center technical staff The purpose of this survey is to understand existing constraints, identify lessons learned, and assess and develop effective strategies for increasing male involvement

We welcome your views and insights on male involvement This exercise is completely voluntary If you are interested in this issue, we encourage you to participate Please fill out the attached questionnaire and return it by August 9, 1996 to POPTECH via mail or fax (see below) or drop it off in the box on Vicki Ellis' door, Room 820 A, SA-18 Please attach documents, notes, and comments, as you wish

If you would like to save time -- or elaborate on your responses -- by speaking to one of us in person, please call POPTECH to make an appointment

We very much appreciate your taking time to help with this study, which we believe will be helpful to both USAID and CAs as we work toward improving reproductive health for both women and men

Thank you for your help

Sincerely,

Nick Danforth
POPTECH Consultant

Cynthia P Green
POPTECH Consultant

Mary Nell Wegner
AVSC International

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PHN Questionnaire on Male Involvement

Note For the purposes of this study, male involvement refers to any activity that seeks to include men, including adult and adolescent males, either individually, in groups, or as part of a sexually active couple, in reproductive health services Male involvement goals include increasing male use of family planning (i e condoms, vasectomy, periodic abstinence, and withdrawal), men's support for female partners' reproductive choices and rights, couple communication regarding reproductive and sexual health, male responsibility for women's and children's health, STDs/HIV prevention and treatment, and development of new male contraceptive methods

Reproductive health services include information and education, counseling, clinical service delivery, social marketing, school- or work-based programs, or any activity to promote reproductive and sexual health, including family planning, safe motherhood, breastfeeding, post abortion and postpartum care and the prevention, diagnosis, and treatment of STDs

If you also know of activities related to the roles of men in child survival, prevention of domestic violence, and female genital mutilation, please include them

1 Do you favor having USAID Global Bureau place a greater emphasis on activities and projects promoting the involvement of men?

____ Yes
____ No

Please comment if desired

2 Is your project in a position to increase activities in the area of involving men in family planning/reproductive health?

____ Yes
____ No

3 If so, do you favor placing greater emphasis on men within your project?

____ Yes
____ No

Please comment

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4 *Within USAID's existing budget constraints*, what do think are the most important actions USAID can take to encourage CAs to promote male involvement? Please rate each item on a 5 point scale (1=not important, 2 = of minor importance, 3= moderately important, 4= quite important, 5= of high priority importance,) Please circle your response

Possible USAID Actions	Circle Your Rating
Improved and increased promotion of condoms	1 2 3 4 5
Improved and increased promotion of vasectomy	1 2 3 4 5
Develop specific indicators for male involvement as part of overall CA project performance goals	1 2 3 4 5
Emphasize to CAs the relative importance of male involvement	1 2 3 4 5
Provide information on country-level strategies to strengthen and expand male involvement activities	1 2 3 4 5
Disseminate lessons learned in male involvement	1 2 3 4 5
Conduct operations research to test models for including men in service delivery	1 2 3 4 5
Develop an RFA or RFP emphasizing involvement of men	1 2 3 4 5
Strengthen FP/RH integration activities that include men	1 2 3 4 5
Strengthen gender analysis in project design	1 2 3 4 5
Other activities? (Please specify)	1 2 3 4 5

5 Constraints to involving men in family planning/reproductive health may exist at several different levels among donors, policymakers, women, in the community They may also vary widely by culture and country **In your experience, what are the primary constraints to efforts to involving men?** In the column at right, circle your rating on a five point scale (1 = not a constraint, 2 = a minor constraint, 3= a moderate constraint, 4 = a significant constraint, 5 = a major, important constraint) Please give examples below under "comments" of countries where you face particular constraints (rated 4 or 5), also attach comments or reports on these countries, or indicate if you would like to discuss them with the researchers

Constraints	Circle Rating
Perceptions and/or attitudes of USAID and USAID missions about male involvement Comments	1 2 3 4 5
Perceptions and/or attitudes of host - country policymakers Comments	1 2 3 4 5
Perceptions and/or attitudes of country - level program managers Comments	1 2 3 4 5
Perceptions and/or attitudes of local service providers Comments	1 2 3 4 5
Community - level cultural constraints Comments	1 2 3 4 5

Opposition among men Comments	1 2 3 4 5
Reluctance among men Comments	1 2 3 4 5
Reluctance among women Comments	1 2 3 4 5
Higher priority given to women's reproductive health Comments	1 2 3 4 5
Perceived opposition due to fear of loss of funds for women's reproductive health Comments	1 2 3 4 5
Perceived opposition among women's health advocates due to loss of control of reproductive health decisions Comments	1 2 3 4 5
Lack of models on how to involve men Comments	1 2 3 4 5
Difficulty integrating men into existing programs emphasizing women Comments	1 2 3 4 5

Difficulty integrating men's reproductive health services into general medical services Comments	1 2 3 4 5
Logistical constraints Comments	1 2 3 4 5
Administrative constraints Comments	1 2 3 4 5
Perceived low cost-effectiveness of men's programs/services relative to women's Comments	1 2 3 4 5
Lack of research measuring results, impacts, benefits of male involvement Comments	1 2 3 4 5
Other constraints (specify)	1 2 3 4 5

6 Following is a list of *ILLUSTRATIVE* activities that the project(s) you monitor may be engaged in Please check those activities that you are aware of

___ Adapting services to serve men, be male-friendly
___ Adapting services to serve couples, be couple-friendly
___ Offering male or couple clinic sessions, hours or sites
___ Increasing access to vasectomy services
___ Promoting condom use

___ Increasing condom sales
___ Training providers to serve couples
___ Training providers to serve men
___ Training traditional practitioners (healers, TBAs)
___ Involving local male leaders (eg Imams, village chiefs)
___ Hiring male community-based distributors
___ Hiring male clinic workers
___ Expanding workplace programs for men
___ Doing research on male KAP in reproductive health
___ Doing more research/evaluation of programs for men
___ Organizing programs for male adolescents
___ Organizing male networks not in health (sports, entertainment, military, etc)
___ Conducting research on male contraceptive methods
___ Providing STD/HIV/AIDS services for males
___ Conducting research on microbicides/spermicides to prevent HIV/AIDS
___ Advocacy and other policy related activities concerning male involvement
Other activities (specify)

7 Are there other activities, research interests, IEC strategies and policies that you think should be explored by USAID or the CAs?

8 Other comments about this issue, or about this study?

Your Name _____

Please send your completed questionnaire by August 9, 1996 Thank you for your cooperation and suggestions

July 24, 1996

Dear Project Director

As part of its study of policies and programs related to male involvement in reproductive health, the PHN Center has asked us to conduct an informal survey of USAID-funded Cooperating Agencies and PHN Center technical staff The purpose of this survey is to understand existing constraints, identify lessons learned, and assess and develop effective strategies for increasing male involvement.

We very much appreciate your taking time, if possible, to help with this study, which we believe will be helpful to both USAID and CAs as we work toward improving reproductive health for both women and men To assure that your responses to this questionnaire are confidential, a number has been assigned to your questionnaire The last page, in which country specific information and project identification is requested, should be detached and mailed separately Please attach documents, excerpts of reports, comments, and suggestions, as you wish, or substitute your own database information for this page,

We welcome your views and insights on male involvement, but do not wish to impose a time-consuming exercise on those CAs with substantial male involvement activities We are available to talk with your representative about specific project activities in lieu of written commentary If you would prefer to speak to one of us in person, please indicate that below (or call POPTECH to make an appointment)

We would appreciate your completing the attached questionnaire to the extent that you can devote the time, and return it by August 15, 1996 to POPTECH via mail or fax As desired, please comment on the variations that you know by project or program, country or region, either in the space provided or on an attachment.

Thank you for your help

Sincerely,

Nick Danforth
POPTECH Consultant

Cynthia P Green
POPTECH Consultant

Mary Nell Wegner
AVSC International

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SURVEY OF MALE INVOLVEMENT ACTIVITIES AMONG CAs

For the purposes of this study, male involvement refers to any activity that seeks to include men, including adult and adolescent males, either individually, in groups, or as part of a sexually active couple, in reproductive health services Male involvement goals include increasing male use of family planning (i e condoms, vasectomy, periodic abstinence/NFP, and withdrawal), men's support for female partners' reproductive choices and rights, couple communication regarding reproductive and sexual health, male responsibility for women's and children's health, STDs/HIV prevention and treatment, and development of new male contraceptive methods

Reproductive health services include information and education, counseling, clinical service delivery, social marketing, school- or work-based programs, or any activity to promote reproductive and sexual health, including family planning, safe motherhood, breastfeeding, post abortion and postpartum care and the prevention, diagnosis, and treatment of STDs

If you also know of activities related to the roles of men in child survival, prevention of domestic violence, and female genital mutilation, please include them

A member of our staff agrees to be interviewed by the POPTECH consultant(s)___ (check if yes)

1 Recognizing that USAID cooperating agencies vary greatly in size and may have more than one project, please indicate whether responding to this questionnaire on the basis of
   ____ a project
   ____ an organization?

2 Please estimate the percentage of your USAID project budget that is spent on male involvement activities (as defined above)

3 What percentage of project *activities* fall into the area of male involvement?

4 Please indicate below those topics for which your organization or your projects have statements of objectives, or results packages If possible, please attach a copy of this

   ___ Male involvement, male participation/responsibility in FP and Health
   ___ Men-only programs or services
   ___ Gender issues, gender equity
   ___ Men as partners, couples, couple-friendly services, married/unmarried couples

___ Adolescent males
___ Teen fathers
___ Others (please specify_____

5 Constraints to involving men in family planning/reproductive health may exist at several different levels among donors, policymakers, and in the community They also vary widely by country or cultural context. **In your opinion, what are the primary constraints to efforts to involve men?** In the table below, circle your rating, (1 = not at all, 2= a small constraint 3= a moderate constraint 4= a considerable constraint, 5 = a major, important constraint.) Please give examples below under "comments" of countries where you face particular constraints (rated 4 or 5)

Constraints	Circle Rating
Perceptions and/or attitudes of USAID and USAID missions about male involvement Comments	1 2 3 4 5
Perceptions and/or attitudes of host - country policymakers Comments	1 2 3 4 5
Perceptions and/or attitudes of country - level program managers Comments	1 2 3 4 5
Perceptions and/or attitudes of local service providers Comments	1 2 3 4 5
Community - level cultural constraints Comments	1 2 3 4 5
Opposition among men Comments	1 2 3 4 5
Reluctance among men Comments	1 2 3 4 5
Reluctance among women Comments	1 2 3 4 5

Male Involvement Survey (CAs)

Higher priority given to women's reproductive health Comments	1 2 3 4 5
Perceived opposition due to fear of loss of funds for women's reproductive health Comments	1 2 3 4 5
Perceived opposition among women's health advocates due to loss of control of reproductive health decisions Comments	1 2 3 4 5
Lack of models on how to involve men Comments	1 2 3 4 5
Difficulty integrating men into existing programs emphasizing women Comments	1 2 3 4 5
Difficulty integrating men's reproductive health services into general medical services Comments	1 2 3 4 5
Logistical constraints Comments	1 2 3 4 5
Administrative constraints Comments	1 2 3 4 5
Perceived low cost-effectiveness of men's programs/services relative to women's Comments	1 2 3 4 5
Lack of research measuring results, impacts, benefits of male involvement Comments	1 2 3 4 5
Other constraints (specify)	1 2 3 4 5

6 *Within your Cooperating Agency,* **please identify the primary constraints to efforts to serve men in family planning/reproductive health programs?** In the table below, circle your rating, ranging from 1 = no constraint, up to 5 = great constraint. Please check the three most important constraints in the left hand margin, and comment if desired

Constraint	Circle Rating
Not seen as part of our primary mandate or purpose	1 2 3 4 5
Lack of research on male involvement	1 2 3 4 5
Lack of funding specified to include male involvement activities	1 2 3 4 5
Lack of IEC materials for and about men	1 2 3 4 5
Lack of trained service providers	1 2 3 4 5
Lack of in-country NGO involvement	1 2 3 4 5
Administrative constraints	1 2 3 4 5
Lack of direction from USAID/W on what to do	1 2 3 4 5
Lack of information from USAID missions	1 2 3 4 5
Lack of internal CA strategies and goals	1 2 3 4 5
Lack of models on how to involve men	1 2 3 4 5
Difficulty integrating males into existing programs	1 2 3 4 5
Women's reproductive health given higher priority	1 2 3 4 5
Logistical constraints	1 2 3 4 5
Perceived less cost-effective than women's programs	1 2 3 4 5
Lack of research on potential impacts or results	1 2 3 4 5
Other constraints? (Please specify)	1 2 3 4 5

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7 From the following illustrative list of male involvement activities, please check those activities that your project is currently supporting, has definite plans to start up in the next two years, or may possibly implement sometime in the future If the activity is not possible or applicable, leave blank

ACTIVITY	CURRENT	PLANNED	POSSIBLE
Adapting services to serve men or be male-friendly			
Adapting services to serve couples or be couple-friendly			
Offering male or couple clinic sessions, hours, sites			
Promoting vasectomy through IEC campaigns			
Increasing access to vasectomy through training, expansion of service sites			
Promoting condom use through IEC campaigns			
Increasing condom sales			
Providing STD/HIV/AIDS services for men			
Promoting STD/HIV/AIDS services through IEC			
Training providers to serve men			
Training providers to serve couples			
Training traditional practitioners (healers, TBAs) to work with men			
Hiring male community-based distributors			
Hiring male clinic workers to work with men			
Expanding workplace programs for men			
Conducting research on male KAP in reproductive health			
Conducting research on programs/services for men			
Organizing programs for male adolescents			
Organizing male networks (sports, entertainment, military, unions, etc) to promote male involvement			
Conducting research on male contraceptive methods			
Conducting research on microbicides/spermicides to prevent HIV/AIDS			
Involving local male leaders (e g Imams, chiefs) in support of FP/MCH/HIV activities			
Conducting social science research on male involvement			
Conducting evaluation of male involvement activities/projects			
Working with policy makers to promote male involvement			
Supporting advocacy and other policy related activities concerning male involvement			
Other activity (specify)			

8 *For CAs working in family planning service delivery, IEC and training* Please provide a "guesstimate" of the breakdown among your clients or audiences between men and women?

%	Clients
___	females
___	males

9 For the men's programs or services your project or organization supports, who are the primary audiences?

___ Adult men in couples
___ Adult men individually
___ Male Youth (15-24)
___ Married Youth
___ Other clients (Please specify)
___ Not applicable

10 Are there information gaps that need to be filled to facilitate male involvement activities in your organization?

11 *Within USAID's existing budget constraints*, what do you think are the most important actions that USAID can take to encourage CAs to promote male involvement? Please rate each item on a scale from 1= not important, to 5 = very important, circle your response In the left hand margin, please place a checkmark next to your three top priorities

Possible USAID Actions	Circle Your Rating
Improve and increase promotion of condoms	1 2 3 4 5
Improve and increase promotion of vasectomy	1 2 3 4 5
Develop specific indicators for male involvement as part of overall CA project performance goals	1 2 3 4 5
Support social science research in male involvement	1 2 3 4 5
Emphasize the relative importance of male involvement in future contract language	1 2 3 4 5
Strengthen HIV/AIDS integration/activities	1 2 3 4 5
Provide information on country-level strategies to strengthen and expand male involvement activities	1 2 3 4 5
Disseminate lessons learned in male involvement more widely	1 2 3 4 5
Conduct operations research to test models for including men in service delivery	1 2 3 4 5
Strengthen gender analysis in project design	1 2 3 4 5
Other activities? (Please Specify)	1 2 3 4 5

12 If current funding levels remain unchanged, does your organization expect that in the coming two years the percent of total funds focused on men will (Recognizing the uncertainties of funding, please give the best "guesstimate" you can)

___ increase significantly
___ increase slightly
___ remain about the same
___ decrease slightly
___ decrease significantly

Thank you for the guidance you have provided by completing this questionnaire Unless you choose to identify your agency, your responses will be held confidential PLEASE MAIL THIS QUESTIONNAIRE NO LATER THAN AUGUST 15TH TO

POPTECH
1611 North Kent St , Ste 508
Arlington, VA 22209

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NOTE Since the following section of the questionnaire cannot be confidential, please mailed separately Please fill out the attached sheet for each country - level male involvement activities of your organization *Alternatively, you may attach reports that contain substantially the same information, and/or you may wish to schedule a meeting with the researchers to discuss these activities*

PROJECTS IN DEVELOPING COUNTRIES WITH MALE INVOLVEMENT FOCUS OR COMPONENT

Please fill out a separate sheet (or attach reports that contain this information) for each project which your CA provides finding or technical assistance to supports male involvement activities Please attach project summaries and progress and evaluation reports, as available Any information on project impact would be especially helpful Alternatively, if this information is currently available in a database, please make note

Name of CA _____

Country _____

Name of Country Project _____

Name of Local Implementing Agency _____

Geographic Area (e g national, district) _____

Name of Database with Project Information _____

Target Population (demographic characteristics, ages, gender, e g newly married couples)

_____

Intervention or Activity

Results, if any

What strategies or approaches worked well? What did not work well? What design features would you change to increase coverage and/or impact?

Please discuss any lessons learned from this project that could be applied to other areas

Person to Contact for More Information

_____

Tel _____ Fax _____ e-mail _____

APPENDIX D

Lessons Learned from this Survey

Interpretation of Questions

Many CAs said they found the questions difficult to answer for several reasons.[8] First, "male involvement" encompasses too many variations—by individual, community, project, culture, and country—to encapsulate easily. Second, the questions were open to different interpretations. Third, it is very difficult for CA staff to assess the responses of its staff members to such complex and subjective questions, particularly in the short time allowed for response. One CA said its responses were "based on hearsay, extrapolation from general experience, not direct experience," and other CAs expressed similar concerns.

Fourth, in trying to simplify the survey by combining several separate objectives under the single goal of "male involvement in reproductive health," respondents found it difficult to differentiate those varied objectives in their responses. For example, most CAs consider that there are at least three possibly very different reasons to involve men in reproductive health:

- To increase gender equity in reproductive health: ensuring that both partners are aware of and respect their partner's needs and choices related to reproductive and sexual health. Instead, some CAs fear that increasing male involvement in reproductive health might increase men's attempts to control their partners. Some CAs believe that family planning is essential for women's empowerment and thus should continue to give women priority.

- To prevent unintended pregnancy: family planning programs have traditionally focused on women, and the CAs listed the major constraint to male involvement to be "the difficulty of integrating men into programs emphasizing women."

- To prevent STD / HIV / AIDS: STD / HIV / AIDS programs usually focus on male clients and condom promotion, have less difficulty involving men, and are very different from family planning programs in their approaches to men and to women.

[8] In fact the investigators had to make trade-offs as in any survey between brevity and clarity: to keep it short (and avoid imposing on overworked CAs who receive too many such questionnaires), but to provide enough detail to analyze this relatively new, complex and sensitive area of gender and health.

There was also uncertainty about the meaning of several survey questions. For example, are men "reluctant" or "opposed" to family planning, or to using family planning services catering to women? And men "opposed" to family planning services may not be opposed to treating their STDs at STD services. Yet the survey questions do not allow such distinctions to be made except in follow-up interviews, which were vital in this study.

Training organizations had a particularly difficult time estimating percentages of budgets or activities because while the trainees in their programs are usually high- or mid-level managers, (about half males), male clients in most of their clinic- or community-based programs number only 1-5 percent.[9]

Concerns about Bias

Some respondents expressed concern that the sample was biased because people favorable to male involvement would be more likely to complete the questionnaire. One PHN respondent said he was "very skeptical about the utility of this [survey] approach to canvassing opinion since this questionnaire is going to be something of a self-fulfilling prophecy given the way it has been designed and delivered."

[9] One training agency estimates that if its management training strengthens reproductive health service delivery, then male involvement activities make up 50 percent of its activities, but only "1-5 percent if direct involvement is the focus."

APPENDIX E

Male Influences on PHN Objectives

Following are some of the issues to be considered in developing male involvement indicators:

1. Reducing unintended pregnancies:

   How many pregnancies are unintended by the man? How often are men involved in unintended pregnancies? What are men's attitudes toward unintended pregnancies? How would men benefit from avoiding unintended pregnancies and having fewer children? How can CAs encourage men to reduce their fertility?

2. Reducing maternal mortality:

   How can men be helpful to women and to the health system in reducing maternal mortality? What are men's attitudes toward safe pregnancy, women's nutrition, and maternal mortality; how do men benefit from preventing maternal deaths; how might CAs get men to help in reducing maternal deaths?

3. Reducing infant and child mortality:

   What are men's attitudes and behaviors regarding infant mortality? How could men help reduce child deaths? How can men benefit from preventing child deaths? How can CAs be more effective in improving the attitudes and roles of men in key child survival and health interventions?[10]

4. Reducing STD / HIV / AIDS transmission:

   What is the extent among women and men of knowledge, availability and quality of HIV / STD services? How aware are men of the risks of STDs and HIV to them and their partners? What do men know about unsafe and safe sex? How can CAs increase men's use of condoms and other safer sex behaviors to reduce STD / HIV / AIDS transmission?

[10] USAID-supported child survival programs are beginning to do operations research to answer such questions about the father's role in child survival interventions. Strategies for involving fathers were a major concern singled out at a global meeting of PVOs sponsored by USAID / FVA / PVC in 1995 (see Child Survival Support Program, 1995 Annual Report, Baltimore, MD, January 1996).

APPENDIX F

A Framework for Assessing Access and Quality of Care for Males

Many questions can be asked at service delivery points (SDPs) to determine whether men as well as women have access to services and whether those services are of adequate quality. These types of questions can help uncover and remedy gender as well as medical barriers; they ask whether gender is a barrier to men who seek information and services to prevent infection and/or unwanted pregnancy. Examples of criteria to be used in assessing SDPs are:

1. Choice of Methods

   Are all methods available to both partners? Are condoms and lubricants easily and confidentially available, affordable, and acceptable to either partner?

   Are providers able to counsel both partners, together and/or separately in condom use and condom negotiation skills?

   Are providers able to counsel both partners about vasectomy benefits and limitations?

   When vasectomy is unavailable at the SDP, are men referred elsewhere for services?

   Can men get help with method-related problems such as impotence, or with problems of infertility?

2. Information to Users

   Are service providers trained to talk to men or, where appropriate, to couples?

   Is counseling of either partner, separately or as a couple, private and confidential?

   Is adequate information about condoms and vasectomy, including audio-visual aids, easily available to either partner, whether seen separately or together?

   Are men and women both told in detail how to use a condom, including the benefits of lubricants?

   Are voluntary surgical contraception (VSC) consent forms signed by the client(s)?

3. Technical Competence

Can provider explain male as well as female methods, including benefits, contraindications, and side effects, including effects on sexuality?

Can the provider explain the details of using condoms and vasectomy in detail, without embarrassment, to either or both partners? If a man or couple chooses to use traditional methods, will he/they be told the advantages and drawbacks of withdrawal, temporary abstinence, or breastfeeding? Is there adequate capability to treat or refer for STDs and HIV?

4. Client-Provider Interaction

Are men welcomed by all SDP staff, from the receptionist to the lab technician to the provider? Do men report feeling welcome and comfortable, as well as competently served? Are service providers trained to talk to individual men, including adolescents, and couples as well as individual women clients? Are trained male (or female) counselors available to serve men if requested?

5. Continuity of Care

Are male clients encouraged to return and able to return as needed? Are follow-up services available where and when men can access them? Do providers identify and deal with men's reasons for not returning?

6. Acceptability and Appropriateness

Are services acceptable and appropriate for men, either as individuals or with partners? Do men find the gender and age of provider or counselor acceptable?

Do men and women perceive the services, facilities, examining rooms, toilets, hygiene, waiting time, clinic hours, etc., appropriate and acceptable? Are these services separated into different hours or facilities for women and men?

Are services accessible to adolescent males?

7. Comprehensiveness

Are a range of reproductive and sexual health services available to men that go beyond traditional maternal and child health care (usually focused on pre- and post-natal care, safe motherhood, and well-baby care primarily for women)?